

06256 *lc*

20. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. *42*

## I. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) \_\_\_\_\_  
 TOWN Lansdowne (In this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS B & O Railroad Crossing

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Kent  
 CITY (If outside corporate limits write RURAL and give nearest town) OR  
 TOWN Millington 14X-2  
 STREET ADDRESS (If rural, give location)  
ADDRESS

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
JOHN H. AHERN (AHERN)

4. DATE OF DEATH (Month) (Day) (Year)  
July 1 19 55

## 5. SEX:

Male

## 6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

## 8. DATE OF BIRTH:

9. AGE last birthday: About 60 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Lumber Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Millington, Md.

12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

John P. Ahern

## 14. MOTHER'S MAIDEN NAME:

Clorinda West

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes W.W. I

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Mrs. Martha Walker- 100 W. University Pkwy.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) Multiple mutilating injuries  
 DUE TO

Antecedent cause(s)

Diseases or conditions, if any, (b) giving rise to the above cause DUE TO stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg. etc.) Injury railroad tracks

21c. (City or town) (County) (State)  
Lansdowne Crossing-Balto. Co. Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY July 1, 1955 A.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?  
Apparently struck by train

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☒.

SIGNATURE

Paul K. Guen

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED  
 DEPUTY MEDICAL EXAMINER ☐  
 M. D. ASSISTANT MEDICAL EXAM. ☒ 7/1/55

## 23. BURIAL, CREMATION, REMOVAL (Specify):

Cremation

## DATE THEREOF

July 15, 1955

## NAME OF CEMETERY OR CREMATORY

Loudon Park

## LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

July 14, 1955 H. A. Hedrick

## 24. FUNERAL DIRECTOR

H. H. Messer & Son- 805 N. Calvert St.

## ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

From Dr. Fishers' letter: "Please code this case in your files as a suicide,  
E979. " 7-20-55 ams

67-2-100-100  
pd

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

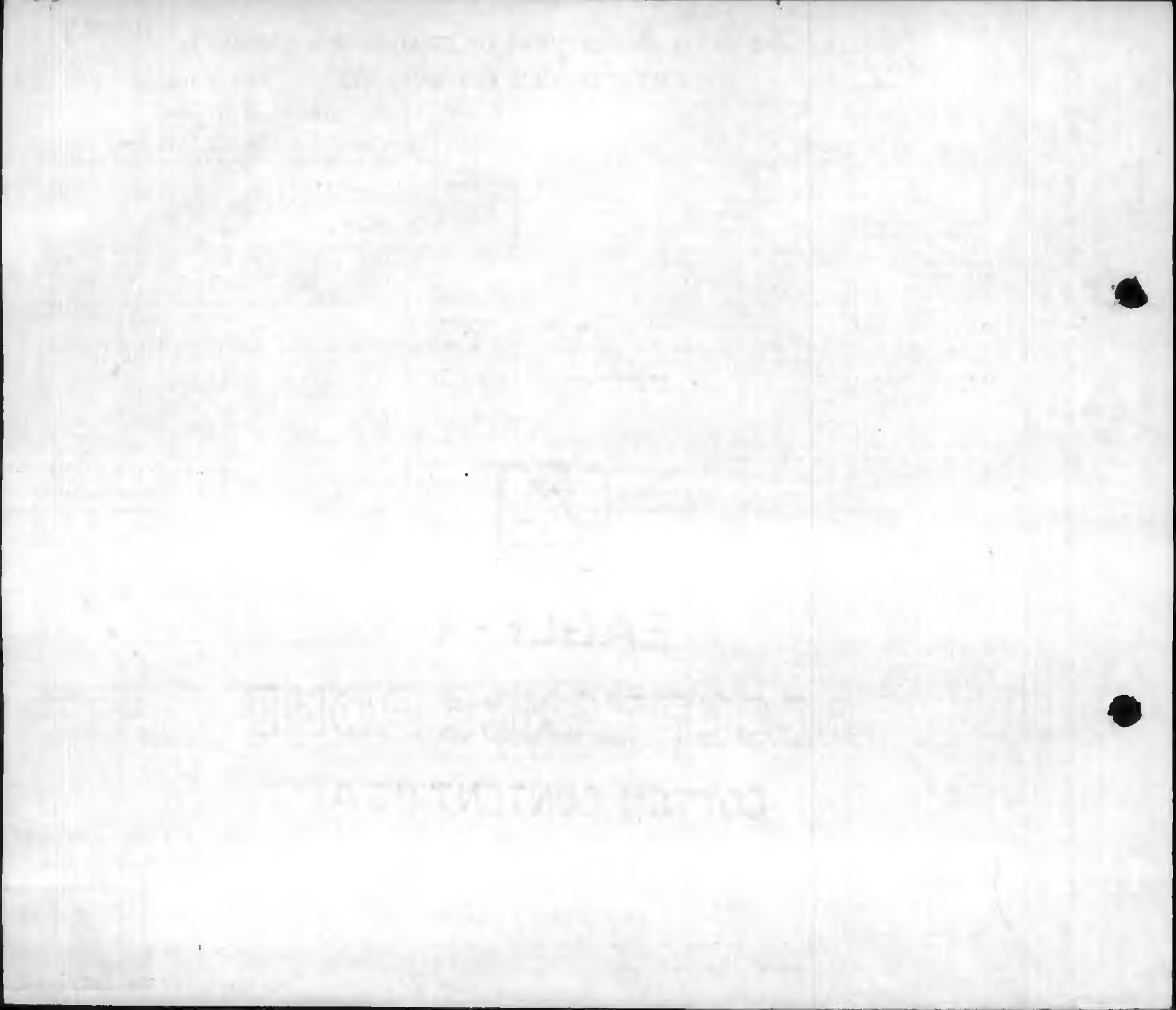
06257

6271

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lutherville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bellona Avenue</u>				STREET ADDRESS (If rural give location) <u>Bellona Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>CHARLES WHITRIDGE AMOS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 18,</u> 19 <u>55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>November 30, 1890</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired - bookbinder</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Mfg. Own Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Marion W. Amos</u>				14. MOTHER'S MAIDEN NAME: <u>Lida Collings</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. C.W. Amos, Bellona Ave., Lutherville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>260X Cerebral thrombosis</u>		DUE TO				<u>Immediate</u>	
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerosis</u>		DUE TO				<u>6 years +</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes mellitus</u>						<u>30 years +</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June, 1950</u> , to <u>July 8, 1955</u> that I last saw the deceased alive on <u>July 14, 1955</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Franklin E. Lohr</u>		ADDRESS <u>M.D. 2929 N. Charles</u>		DATE SIGNED <u>7/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 21, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/20/55</u>		REGISTRAR'S SIGNATURE <u>W. Hedrick</u>		24. FUNERAL DIRECTOR <u>John Burton Sonar</u>		ADDRESS <u>Towson, Maryland</u>	





6272  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06258-

Reg. Dist.

No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Essex</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Essex</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>1630 B. Dartford Road</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>GLENN</u>		(Middle) <u>WILLIAM</u>		(Last) <u>ANDERSON</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Oct 16 1916</u>	
9. AGE last birthday: <u>38</u> yrs.		4. DATE OF DEATH: <u>7</u> <u>29</u> <u>19</u> <u>5</u>		10. KIND OF BUSINESS OR INDUSTRY: <u>Orchard</u>		11. BIRTHPLACE (State or foreign country): <u>Va.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Orchard</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME: <u>James H. Anderson</u>				14. MOTHER'S MAIDEN NAME: <u>Naunie Tuehl</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		(If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>155-18-9677</u>		17. INFORMANT & ADDRESS: <u>Archie Anderson 514 12 orsey Ave.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>491X Immediate cause (a) <u>Acute early bronchopneumonia</u></p> <p>Antecedent cause(s) (b) <u>DUE TO</u></p> <p>Diseases or conditions, if any, giving rise to the above cause (c) <u>DUE TO</u></p> <p>stating underlying cause last (c) <u>DUE TO</u></p>							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>7/30/55</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>William V. Wood</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/29/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF: <u>7/30/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Reins Sturdivant</u>		LOCATION (City, town, or county) (State): <u>Boone North Carolina</u>	
DATE REC'D BY LOCAL REG. <u>AUG 1 1955</u>		REGISTRAR'S SIGNATURE <u>William V. Wood</u>		24. FUNERAL DIRECTOR <u>Christine Bryn Linder</u>		ADDRESS <u>1407 Eastern Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE MORQUE

BUREAU V. I.

AUG 4 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

6273

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MARYLAND</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Charmelle</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Baltimore County</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>504 Windwood Road</b>		STREET ADDRESS (If rural, give location) <b>504 Windwood Road</b>	
3. NAME OF DECEASED (Type or Print) <b>KATHERINE THERESA BALLARD</b>		4. DATE OF DEATH (Month) <b>7/8/55</b> (Day) <b>19</b> (Year)	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, <b>Widowed</b> (Specify)	8. DATE OF BIRTH <b>1880</b>
9. AGE last birthday <b>75</b> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Co.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Matthew Kelly</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Clancey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT AND ADDRESS <b>Miss M. Ballard-504 Windwood Rd.</b>			

## 13. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X

Immediate cause (a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

Primary aneurysm

INTERVAL BETWEEN ONSET AND DEATH

12 hrs

5 yrs

5 yrs

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY m.INJURY OCCURRED  
While at Not While  
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1950., to July 8, 1955., that I last saw the deceased

alive on July 7, 1955., and that death occurred at 12:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

WIEDEFELD &amp; SON

GREENMOUNT AVE &amp; 22ND

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1855  
1855  
1855  
1855  
1855

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6274 CERTIFICATE OF DEATH

06260

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTO. CO</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>BALTO</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CATONSVILLE 28 52</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 WAYNE CONV. HOME</u>		STREET ADDRESS (If rural give location) <u>DE LAET AVE.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MINNIE W. BARDWELL</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>7/2/55</u> 19	
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>2/20/1866</u>
9. AGE last birthday: <u>89</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>U.S. govt. bookbinding</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>and</u>	
11. BIRTHPLACE (State or foreign country): <u>and</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME: <u>Lynch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S ADDRESS: <u>Mrs. E. E. Hoot</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
241X IMMEDIATE CAUSE		(A) <u>Hypertensive Cardio-Vascular</u>	
ANTECEDENT CAUSE (S)		(B) <u>Dissecting</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Bronchial Asthma</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized Hypertrophic Arthritis</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>7/2/55</u> , that I last saw the deceased alive on <u>6/29/55</u> 19 <u>55</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>7/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>7/4/55</u>	
NAME OF CEMETERY OR CREMATORY: <u>LOUDON PARK</u>		LOCATION (City, town, or county) (State): <u>BALTO. MD</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>July 4, 1955</u>		REGISTRAR'S SIGNATURE: <u>[Signature]</u>	
24. FUNERAL DIRECTOR: <u>[Signature]</u>		ADDRESS: <u>[Address]</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. R.

JUL 6 1955

RECEIVED



6275

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN <u>Woodlawn, Maryland</u>		<input checked="" type="checkbox"/> TOWN <u>Woodlawn, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		<u>2229 Southland Road</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Katherine K. Bauman</u>	(Middle)	(Last)	(Month) (Day) (Year)
(Type or Print)		<u>July 28, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>March 2, 1883</u>
		9. AGE last birthday: <u>72</u> yrs.	10. IF UNDER 24 HRS. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At Home</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>George Bernard Bauman 2229 Southland</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of colon</u>			<u>2 1/2 yrs.</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Antenatal C-V disease</u>			<u>15 yrs.</u>
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/10</u> , 19 <u>57</u> , to <u>July 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 28</u> , 19 <u>59</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Allen Phochal</u>		DATE SIGNED <u>7/21/59</u>	
ADDRESS <u>4111 Liberty Heights Ave</u>		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>August 1, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR		4600 Liberty Heights Avenue	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6276

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH				2 USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <b>BALTIMORE</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY <b>2, 7.</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>FORT HOWARD</b>		<b>105 DAYS</b>		OR TOWN <b>ARNOLD</b>		<b>C2X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>Rt#2 Box 584</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>VICTOR H BELMONT</b>				4. DATE OF DEATH: (Month) (Day) (Year) <b>JULY 12 1955</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>4/11/90</b>	
9. AGE last birthday <b>65 yrs</b>		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if deceased) <b>CRIB ATTENDANT</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>G.L. MARTIN &amp; CO.</b>			
13. FATHER'S NAME <b>VICTOR BELMONT</b>				14. MOTHER'S MAIDEN NAME <b>IDA MN: UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <b>YES WW-I</b>				16. SOCIAL SECURITY NO. <b>138 03 2572</b>			
17. INFORMANT & ADDRESS <b>CLIN.REC.VET.ADM.HOSP., FT.HOWARD, MD.</b>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>163X CARCINOMA LUNG, RIGHT</b>						<b>3 YEARS</b>	
ANTECEDENT CAUSE (B) <b>DUE TO</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST <b>260X</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>DIABETES MELLITUS</b>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that <b>X VA</b> attended the deceased from <b>Mar. 29, 1955</b> to <b>July 12, 1955</b> , and that death occurred at <b>4:00 PM.</b> from the causes and on the date stated above.							
SIGNATURE <b>WILLIAM COOK</b>		DATE SIGNED <b>7/12/55</b>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>7-15-55</b>		NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
DATE REC'D BY LOCAL REGISTRAR <b>7/13/55</b>		REGISTRAR'S SIGNATURE <b>A.W.Hedrich dmr.</b>		24. FUNERAL DIRECTOR <b>WILLIAM COOK FUNERAL HOME</b> ADDRESS <b>St. Paul &amp; Preston Sts. Balto, Md.</b>			

MARGIN RESERVE FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



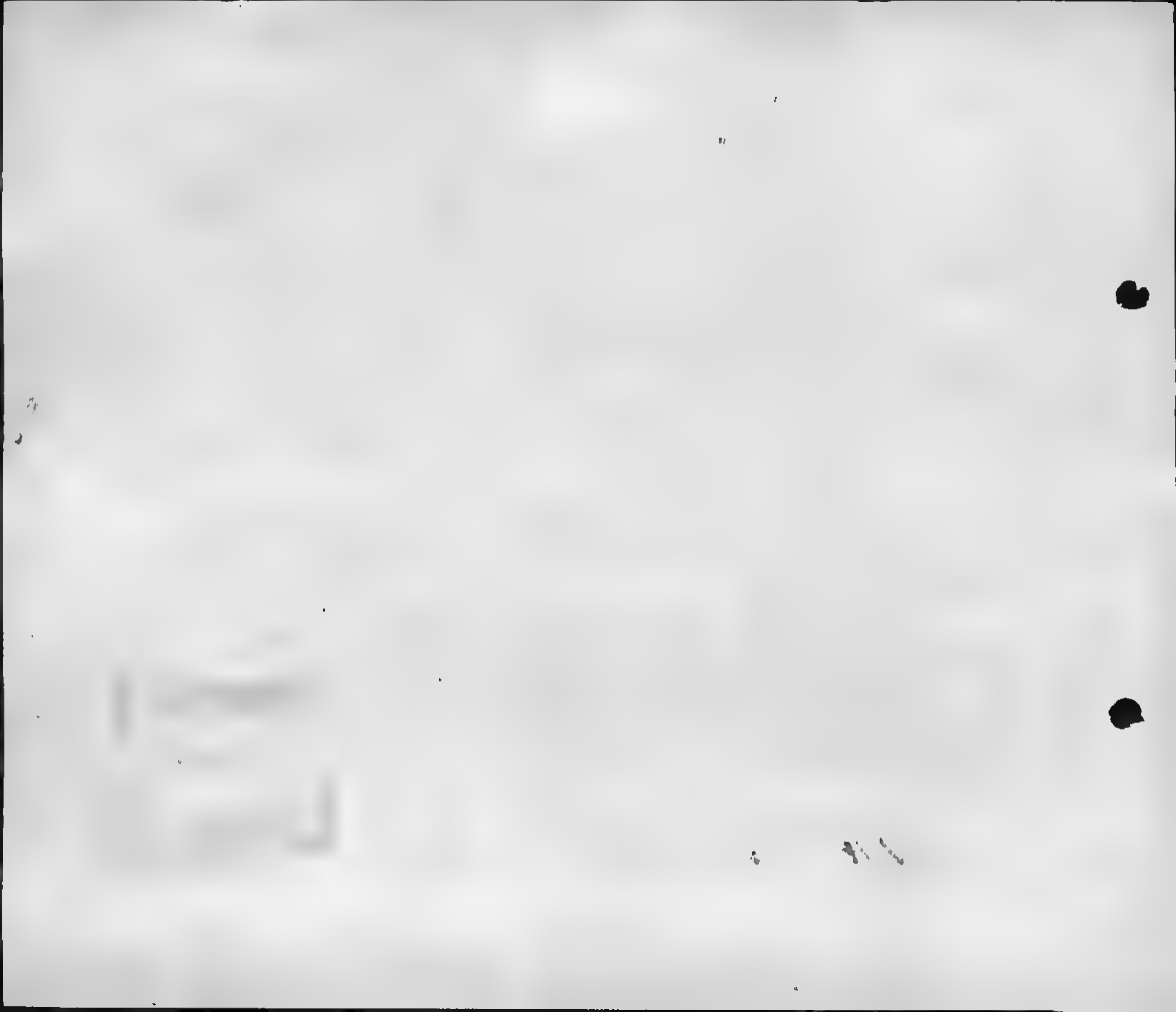
## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Pikesville</u>		LENGTH OF STAY (in this place) <u>16 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Robb Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Essex Road</u>		/	
3. NAME OF DECEASED (Type or Print) (First) <u>Addie</u> (Middle) <u>Lurie</u> (Last) <u>Berryman</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July</u> <u>16</u> <u>1955</u>					
5. SEX. <u>F</u>	6. COLOR OR RACE: <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept 10 1868</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT & ADDRESS: <u>Oliver C Berryman Reisterstown Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u> (A) <u>Chronic Myocarditis</u>						<u>6 mos</u>	
ANTECEDENT CAUSE (B) <u>Coronary Arteriosclerosis</u>						<u>2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension</u>						<u>5 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis</u>						<u>2 yrs.</u>	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/9</u> , 19 <u>53</u> , to <u>7/16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/16</u> , 19 <u>55</u> , and that death occurred at <u>9.40</u> M, from the causes and on the date stated above.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 19 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7.19.55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		24. FUNERAL DIRECTOR <u>Wm Berryman &amp; Sons</u>		ADDRESS <u>Reisterstown Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

6250

## CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Item 7, Fil-GLR4 8-4-55 et

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <u>BALTO</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>DUNDALK</u>		LENGTH OF STAY (in this place) <u>15 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK (22)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>204 ST. HELENA AVE.</u>				STREET ADDRESS (If rural, give location) <u>204 ST. HELENA AVE.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>HAROLD</u>	(Middle) <u>GODFREY</u>	(Last) <u>BERTRAM</u>	4. DATE OF DEATH	(Month) <u>JULY</u> (Day) <u>28</u> (Year) <u>1955</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JULY 20, 1888</u>	9. AGE last birthday <u>67</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RECLAMATION OF WIRE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WELDING EQUIP.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>ROBERT H. BERTRAM</u>		14. MOTHER'S MAIDEN NAME <u>DRUCILLA (UNK)</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVEN IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>218-03-0473</u>		17. INFORMANT AND ADDRESS <u>MRS. MINNIE B. BERTRAM - SAME</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Hypertensive Cardio Vascular Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

5 6 yrs

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BURIAL AUG. 1, 1955 BALTIMORE BALTIMORE, MD.

July 30-1955 William M. Kelly Kelly & Sons, Dundalk, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BURMAN A. S.

1965

06266

## MARYLAND STATE DEPARTMENT OF HEALTH

6278

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fullerton</u> LENGTH OF STAY (in this place) <u>3 1/2</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fullerton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Perry Hall Lane</u>		STREET ADDRESS (If rural, give location) <u>Perry Hall Lane</u>	
3. NAME OF DECEASED (First) <u>Daisy</u> (Middle) <u>L</u> (Last) <u>Billingsley</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 11-1896</u>
9. AGE last birthday <u>58</u> yrs.		10. If under 1 year Months Days If under 24 h. Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Martin</u>		14. MOTHER'S MAIDEN NAME <u>Clarence Billingsley Perry Hall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mr Clarence Billingsley Perry Hall</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
157X Immediate cause (a) <u>Removal of Lung from metastatic Carcinoma</u>		<u>Sudden</u>	
Antecedent cause(s) (b) <u>Primary site Carcinoma of Pancreas</u>		<u>3 1/2</u>	
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Primary site Carcinoma of Pancreas</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death			
19a. DATE OF OPERATION <u>7/20/55</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory, street, or office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, and that said deceased died on the day stated above, and death in my opinion resulted from natural causes <u>accident</u> , suicide, homicide, undetermined.			
SIGNATURE <u>Charles F. Donnell md</u> (Degree or title)		ADDRESS <u>7501 Yacht Rd Towson Md</u>	
DATE SIGNED <u>7-19-55</u>		DATE SIGNED	
23. RIAL CREMATION (Specify) <u>Burial</u>		DATE THEREOF <u>7/20/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mount Airy</u>		LOCATION (City, town, or county) (State) <u>Balto md</u>	
24. FUNERAL DIRECTOR <u>Laasalu Funeral Home</u>		ADDRESS <u>7401, Belair Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. A15A

106

06267

## MARYLAND STATE DEPARTMENT OF HEALTH

6279

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ruthton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ruthton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6506 Darnall</u>		STREET ADDRESS (If rural, give location) <u>6506 Darnall Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u> (Middle) <u>Lavarne</u> (Last) <u>Bitner</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 16 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>October 8, 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	9. AGE last birthday <u>55 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John S. Bitner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Eliz Bobblitz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes N.W. #1</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Marguerite Bitner- 6606 Darnell Rd.</u>			

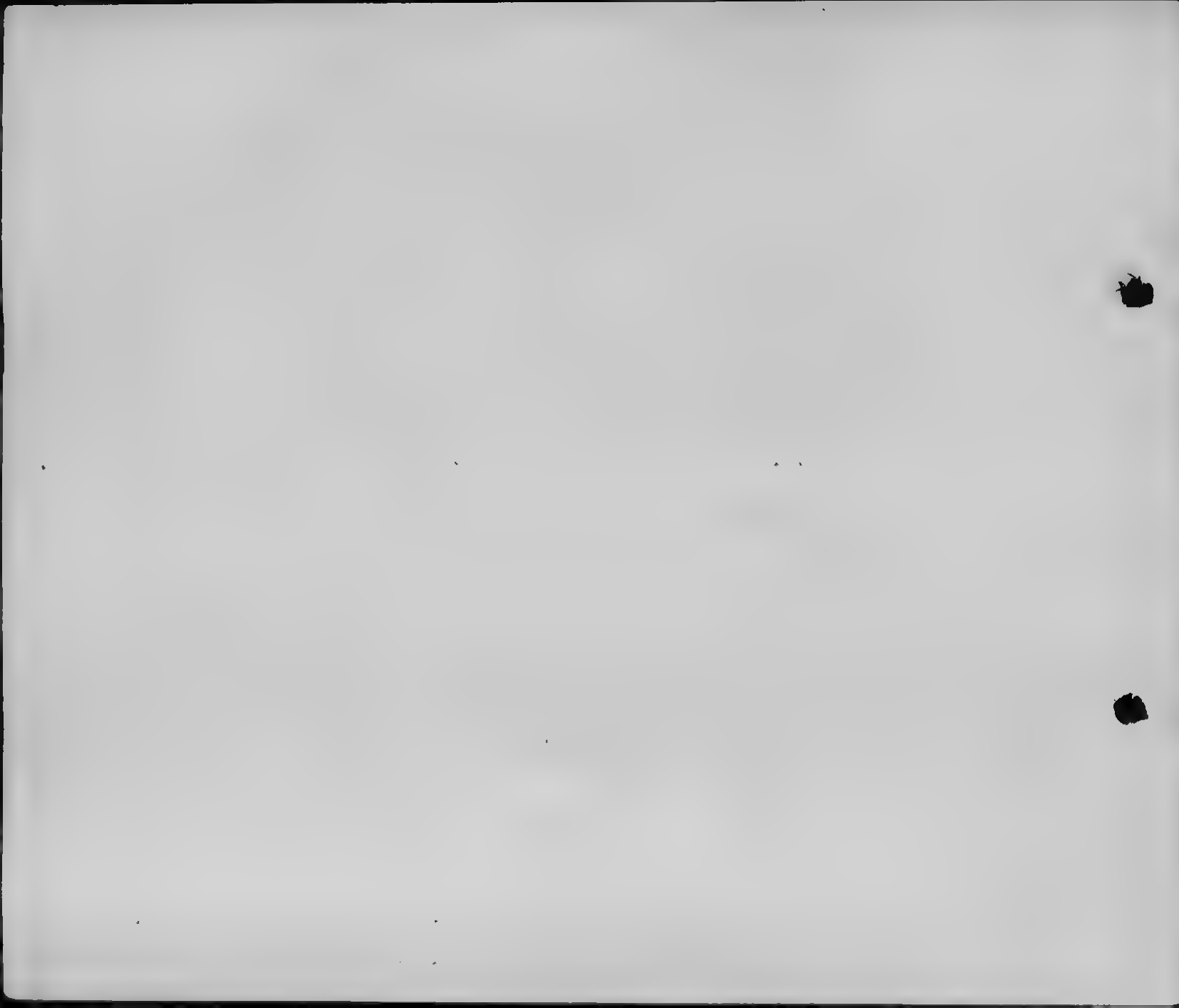
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u>		<u>Sudden</u>
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____ (c) _____		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> , <u>accident</u> , <u>suicide</u> , <u>homicide</u> , <u>undetermined</u> .			
SIGNATURE <u>Charles Chonnell MD</u>		ADDRESS <u>7501 York Rd - Towson 4 Md</u>	
DATE SIGNED <u>7/19/55</u>		DATE SIGNED	
23. CREMATION (If yes, by)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7/19/55</u>	<u>Druid Ridge Cem.</u>	<u>Pikesville, Md.</u>
DATE RECD BY LOCAL REGISTRAR'S SIGNATURE <u>1/18/55 W.A. Hedrich</u>		21. FUNERAL DIRECTOR <u>Wm. J. Tiekner &amp; Sons Balto. 17, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the cause of death clearly and legibly.





6280

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> , COUNTY <u>1</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>X</u>	
<u>X</u> TOWN <u>Rosedale</u>				STREET ADDRESS (If rural give location)		<u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1217 Neighbors Ave.</u>				STREET ADDRESS <u>1217 Neighbors Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		5. DATE OF DEATH: (Month) (Day) (Year)			
<u>Harris B. Blackwell</u>		<u>July 3 1955</u>		<u>July 3 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>July 29, 1918</u>	
9. AGE last birthday <u>36</u> yrs.		10. UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Machinist</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Glenn L. Martin</u>			
13. FATHER'S NAME: <u>V. R. Blackwell</u>				14. MOTHER'S MAIDEN NAME: <u>Alysie Blackwell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or blank.) (If Yes, give war or dates of service) <u>Yes W. W. 2</u>				16. SOCIAL SECURITY NO.: <u>225-05-9401</u>		17. INFORMANT & ADDRESS: <u>Dorothy D. Blackwell-1217 Neighbors Ave.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>PULMONARY EMBOLISM</u>						<u>2 minutes</u>	
ANTECEDENT CAUSE (B) <u>THROMBOPHLEBITIS (FEMORAL)</u>						<u>2 WEEKS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>JULY 25, 1955</u> , to <u>JULY 3, 1955</u> , that I last saw the deceased alive on <u>JULY 2, 1955</u> , and that death occurred at <u>3:15 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>849 Philadelphia Rd. 346</u>		DATE SIGNED <u>Feb 3, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>July 4, 1955</u>		<u>Blackwell's Chapel</u>		<u>Meadow View, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4-1554</u>		<u>[Signature]</u>		<u>Chas. C. Coker Inc - 1217 St Paul St</u>		<u>[Signature]</u>	

MARGIN RESERVED FOR BINDING

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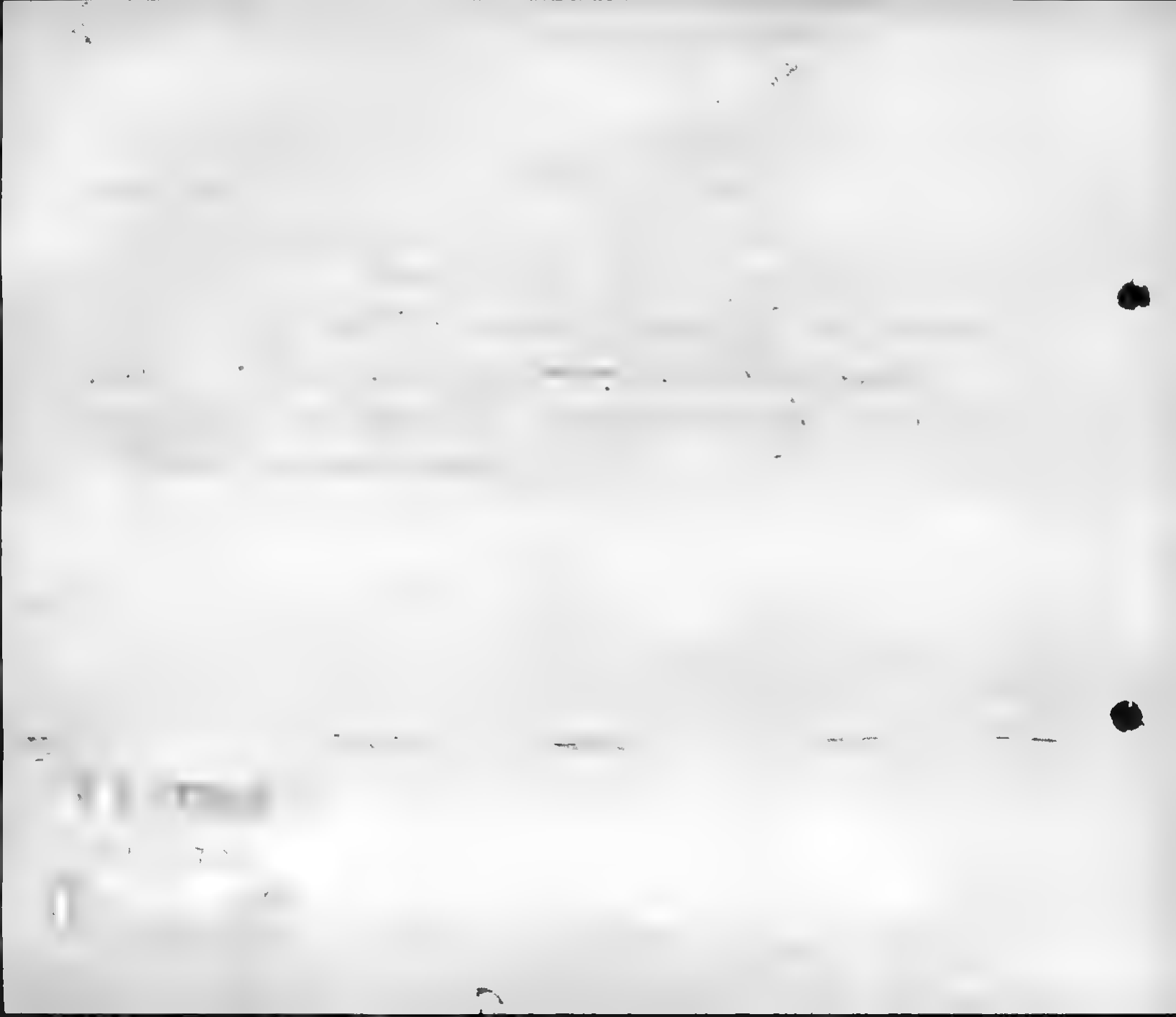
## CERTIFICATE OF DEATH

Reg. Dist. No. 33

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X <u>Rural - Freeport</u>		<u>9 1/2</u>		OR TOWN <u>Rural - Freeport</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bridge Rd.</u>				STREET ADDRESS (If rural give location)		<u>Bridge Rd.</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)			
<u>Mary Ellen Blevins</u>				DEATH <u>July 15</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SPECIFY	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>December 10 - 1866</u>	<u>88</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)				11. BIRTHPLACE (State or foreign country):			
<u>House w/o Own home</u>				<u>Ash Co N.C.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Calvin Blevins</u>				<u>Nancy Duncanson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
<u>No</u>				<u>Freeport MD</u>			
17. INFORMANT'S ADDRESS:				18. MEDICAL CERTIFICATION			
<u>Freeport MD</u>				19. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE <u>422.1</u>							
ANTECEDENT CAUSE (S)				(A) <u>Cardio-vascular disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO			
				(B)			
				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22 I hereby certify that I attended the deceased from <u>7/15</u> , 19 <u>55</u> , to <u>7/15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/14</u> , 19 <u>55</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Frances</u>		<u>M. D. Parkton</u>		<u>7/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (city, town, or county) (State)	
<u>Burial</u>		<u>July 18, 1955</u>		<u>St. John's</u>		<u>Chilhowee Va</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7/10/55</u>		<u>Robert L. Luster</u>		<u>Jacob H. Hostenstein</u>		<u>New Bedford Va.</u>	



6282

## CERTIFICATE OF DEATH

Reg. Dist. No.

ily. The

THIS IS A PERMANENT RECORD. PLEASE TYPE IN PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information carefully supplied. Physicians: please state the causes of death clearly and legibly. THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER THE DEATH.

1. NAME OF DECEASED (Type or Print) <b>MARY PLEASANTS BONSALE</b>			2. DATE OF DEATH <b>July 3 1955</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>X Baltimore County</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>30 Mercy Villa</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto Monkton X</b>		
C. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>Mercy Villa Baltimore Ave</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Nov 30 1863</b>	9. AGE (In years last birthday) <b>91</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>Balto Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Jacob Hall Pleasants</b>			14. MOTHER'S MAIDEN NAME <b>Margaretta Riggs</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>✓</b>		
17. INFORMANT <b>W W Lanahan Booklandville Md.</b>			ADDRESS		
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardio-Vascular Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Generalized Arteriosclerosis</b>					<b>5 yrs</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
IF OPERATION WAS RELATED TO CAUSE OF DEATH ENTER IN		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY
22. I certify that (I) (this hospital) attended the deceased from <b>6/1</b> to <b>7/3</b> 19 <b>55</b> , that (I) (we) last saw the deceased alive on <b>7/2</b> 19 <b>55</b> , and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>M.D. [Signature]</b>		23B. ADDRESS <b>11 E. Chase St.</b>		23C. DATE SIGNED <b>7/5/55</b>	
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>July 5 1955</b>	24C. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 4 1955</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR <b>H W Jenkins Son Co 4905 York Rd</b>	
REGISTRAR					





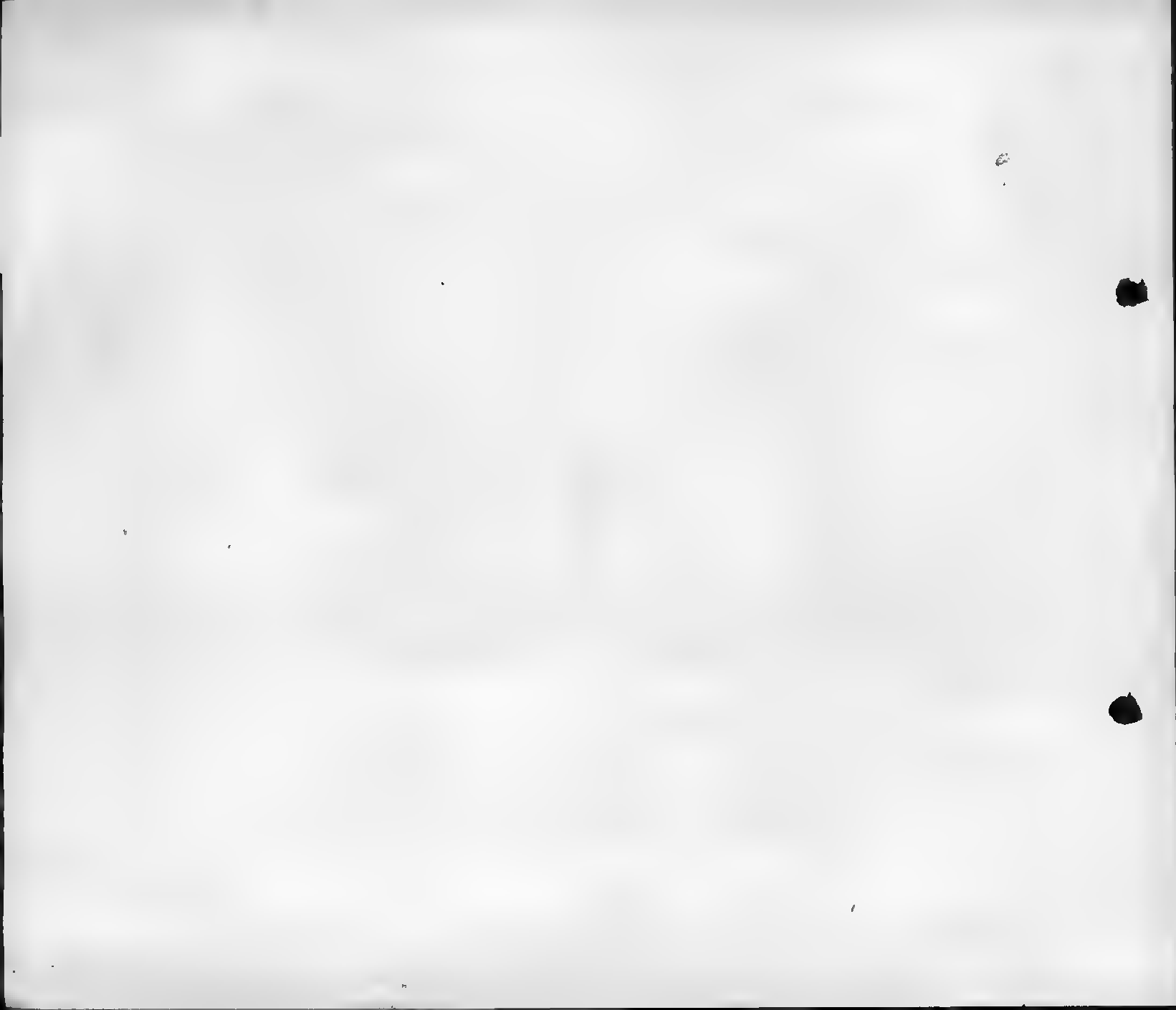
## 6282 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		
CITY (If outside corporate limits, write RURAL and give nearest town)			CITY (If outside corporate limits, write RURAL and give nearest town)		
OR TOWN <u>Edgemere</u> LENGTH OF STAY (in this place) <u>15 Yrs.</u>			OR TOWN <u>Edgemere</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2828 Lodge Farm Road</u>			STREET ADDRESS (If rural give location) <u>2828 Lodge Farm Road</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)		
<u>Silas Bowen</u>			OF DEATH: <u>July-15th-1955</u>		
5. SEX: <u>Male</u>			6. COLOR OR RACE: <u>Col.</u>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Widowed</u>			8. DATE OF BIRTH: <u>Nov-19-1890</u>		
9. AGE last birthday <u>64</u> yrs.			10. BIRTHPLACE (State or foreign country): <u>Virginia</u>		
11. CITIZEN OF WHAT COUNTRY? <u>American</u>			12. FATHER'S NAME: <u>Unknown</u>		
13. MOTHER'S MAIDEN NAME: <u>Unknown</u>			14. INFORMATION & ADDRESS: <u>Lacey Bowen 2828 Lodge Farm Road</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		
17. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			4 days		
IMMEDIATE CAUSE (A) <u>Broncho-pneumonia</u>					
ANTECEDENT CAUSE (B) <u></u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>					
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 1st 1955</u> , to <u>July 15/55</u> , that I last saw the deceased on <u>July 15/55</u> , and that death occurred at <u>5:30 A.</u> from the causes and on the date stated above.					
23. REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Lt. Calvary</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S ADDRESS: <u>Elroy O. Wilson 2804 Villanova St</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.



6284

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lochearn</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lochearn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3619 Oak Ave.</u>		STREET ADDRESS (If rural give location) <u>3619 Oak Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHESTER O. BOYD</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>JULY 30 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>May 16, 1883</u>
9. AGE last birthday <u>72</u> yrs.		10. UNDER 1 YEAR: Months Days	11. UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk baggage B&amp;O R. R.</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Robert H. Boyd</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Klaus</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-05-2158</u> <u>B&amp;O 440-250</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Kenneth L. Upperoue 3619 Oak Ave. 7</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>		<u>2 HRS.</u>	
ANTECEDENT CAUSE (B) <u>CORONARY ARTERIOSCLEROSIS</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>BENIGN ESSENTIAL HYPERTENSION</u>		<u>1 YR.</u>	
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>JUNE 19, 1953</u> to <u>JULY 30, 1955</u> , that I last saw the deceased alive on <u>JULY 30, 1955</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Marvin Goldstein</u>		DATE SIGNED <u>JULY 30, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Oak Cem</u>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>William J. Tuckers</u>	
		ADDRESS	



6285

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL or give nearest town) <u>52 Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1301 Edmondson Ave</u>		STREET ADDRESS (If rural give location) <u>1301 Edmondson Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Edna B. Brinkmann</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>July 12, 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, D. VORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>May 5, 1884</u>
9. AGE last birthday <u>71</u> yrs		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>A. W.</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13. FATHER'S NAME <u>Charles F. Wacker</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Schaur</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT & ADDRESS <u>Carsten S. Brinkmann 1301 Edmondson Ave</u>			
18. MEDICAL CERTIFICATION			
18a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>422.1</u>			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(A) <u>arterio sclerotic</u>			
(B) <u>Cardio-vascular Heart disease</u>			
(C)			
19. OR SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	
21c. WHERE DID (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
21e. TIME (Month, (Day) (Year) (Hour) OF INJURY		21f. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>July 7, 1955</u> , to <u>July 12, 1955</u> , that I last saw the deceased alive on <u>July 10, 1955</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Walter J. Ford</u>		ADDRESS <u>1118 N. Paul St. Baltimore, Md.</u>	
DATE SIGNED <u>7/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7/15/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-13-55</u>		REGISTRAR'S SIGNATURE <u>Harry F. Witke</u>	
24. FUNERAL DIRECTOR <u>Harry F. Witke</u>		ADDRESS <u>4101 Edmondson Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6286 CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

COUNTY Balto MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) Towson  
 OR TOWN Towson LENGTH OF STAY (in this place) ?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY ✓  
 CITY (If outside corporate limits, write RURAL and give nearest town) Balto  
 OR TOWN Balto 3rd 1-4  
 STREET ADDRESS (If rural give location) 5506 Craig Ave

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
 (Type or Print) MARY FALCONER BRISTOL

4. DATE OF DEATH: (Month) (Day) (Year)  
July 3 1955

## 5. SEX:

F

## 6. COLOR OR RACE:

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Widow

## 8. DATE OF BIRTH:

July 31 1868

## 9. AGE last birthday:

86 yrs.

10. UNDER 1 YEAR 11. MONTHS 12. DAYS 13. HOURS 14. MIN.

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY:

Frederick Md

11. BIRTHPLACE (State or foreign country): U.S.A.  
 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

Wm H Falconer

## 14. MOTHER'S MAIDEN NAME:

Mary Boteler

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

4 No

## 16. SOCIAL SECURITY No:

## 17. INFORMANT &amp; ADDRESS:

C Edwin BristolSame

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4 IX

Immediate cause

(a)

Lobular pneumonia

DUE TO

## Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death  
10 days

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Semility

## 19a. DATE OF OPERATION:

None

## 19b. MAJOR FINDINGS OF OPERATION

15 yrs.

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

None

PLACE (Home, farm, factory, street, office bldg., etc.)  
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY None m.

## INJURY OCCURRED

While at Work ☐Not While At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 15, 1952, to July 3, 1955, that I last saw the deceased

alive on July 27, 1955, and that death occurred at 4:10 pm from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## DATE THEREOF

July 5 1955

## NAME OF CEMETERY OR CREMATORY

Lorraine Park

## LOCATION (City, town, or county) (State)

Hoodlawn Md

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

Edwin Bristol

## 24. FUNERAL DIRECTOR

Edwin Bristol

## ADDRESS

4905 York Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE DIAMOND WITH UNFADING INK. Supply every item of information requested.

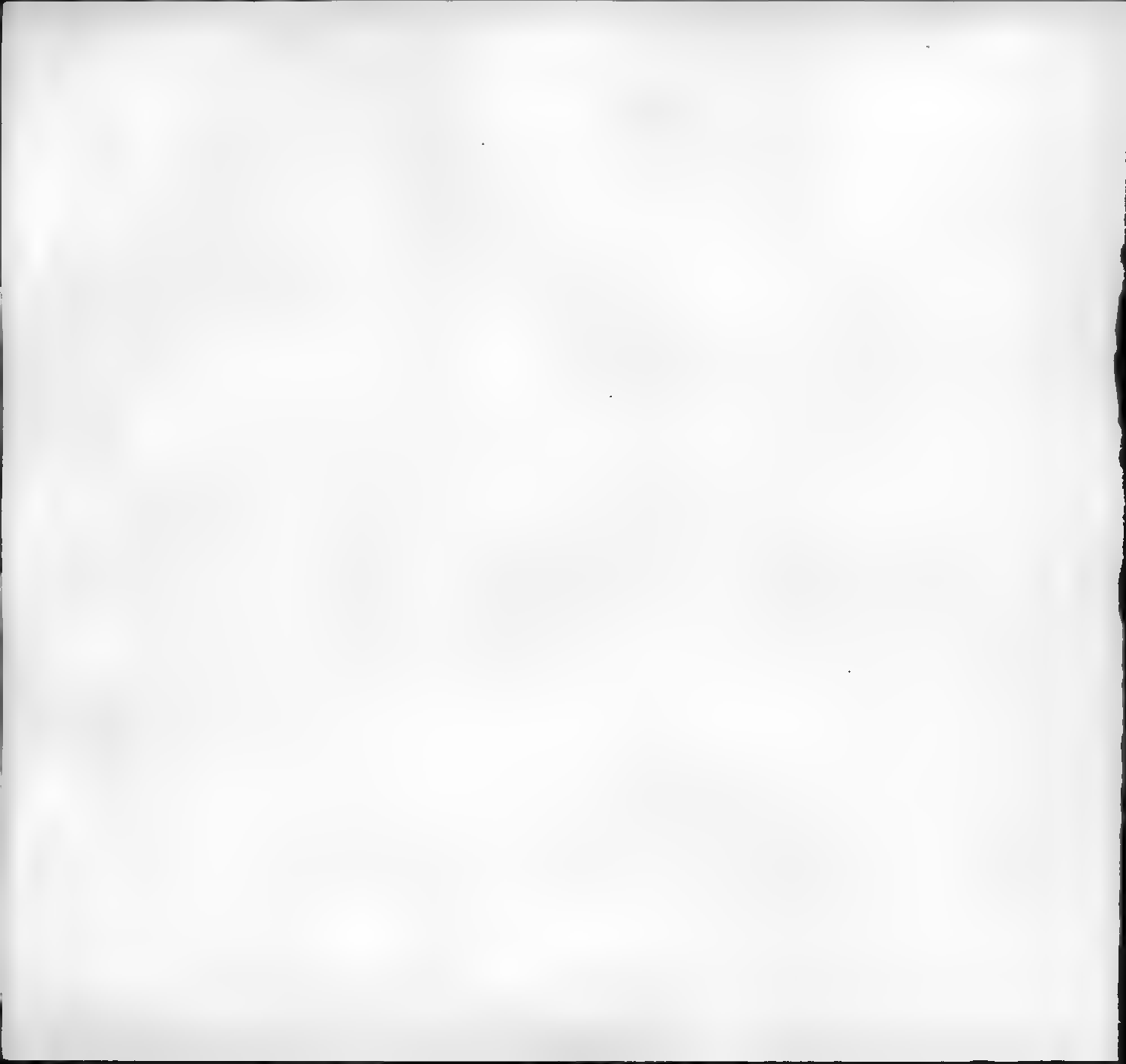




6287

## Reg. Dist. No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1. PLACE OF DEATH

COUNTY **BALTIMORE** MARYLAND  
CITY (If outside corporate limits, write RURAL and give nearest town) **FORT HOWARD**  
TOWN **FORT HOWARD** LENGTH OF STAY (in this place) **34 DAYS**

HOSPITAL OR INSTITUTION OR STREET ADDRESS **VETERANS ADMINISTRATION HOSPITAL**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MARYLAND** COUNTY **CALVERT**  
CITY (If outside corporate limits, write RURAL and give nearest town) **ISLAND CREEK**  
TOWN **ISLAND CREEK**

STREET ADDRESS (If rural give location) **04X 2**

3. NAME OF DECEASED (Type or Print)

First (Last) (Middle)

**JOHN L. BROOKS**

5 SEX

**MALE**

6 COLOR OR RACE **COLORED**

7 SINGLE MARRIED, WIDOWED, DIVORCED (Specify) **DIVORCED**

8. DATE OF BIRTH:

**9-9-93**

4. DATE (Month) (Day) (Year)

OF DEATH **JULY 26 1955**

9. AGE last birthday, if under 1 year, if under 24 hrs. **61** yrs Months Days Hours Min

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**MAIL CARRIER FEDERAL GOVERNMENT**

10B. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country) **ISLAND CREEK, MARYLAND**

12. CITIZEN OF WHAT COUNTRY?

**U. S. A.**

13. FATHER'S NAME:

**DAVID BROOKS**

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)

**YES WW I**

16 SOCIAL SECURITY NO.

**Unknown**

14. MOTHER'S MAIDEN NAME **QUEENIE SPRIGGS**

17 INFORMANT & ADDRESS:

**CLIN.REC.VET.ADM.HOSP.,FT.HOWARD, MD.**

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**199.1**

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

18. MEDICAL CERTIFICATION

(A) **ANAPLASTIC SARCOMA, LEFT UPPER EXTREMITY, WITH GENERALIZED METASTASES**

(B) DUE TO

(C)

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

**1 YEAR-Plus**

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While at work Not while at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that **VA** attended the deceased from **JUNE 22, 1955**, to **JULY 26, 1955**, and that death occurred at **1:30AM**, from the causes and on the date stated above.

SIGNATURE

**FRANCIS G. DICKEY, M.D., Chief, Medical Service**

ADDRESS

DATE SIGNED

**VAH, FORT HOWARD, MARYLAND 7-26-55**

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

**BURIAL**

NAME OF CEMETERY OR CREMATORY

**BROOKS CEMETERY**

**MUTUAL, MARYLAND**

DATE REC'D BY LOCAL REGISTRAR SIGNATURE

**Aug 1 1955**

24. FUNERAL DIRECTOR

**SEWELL FUNERAL HOME,**

ADDRESS

**PRINCE-FREDERICK, MARYLAND**

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**THE MURDER**

6289

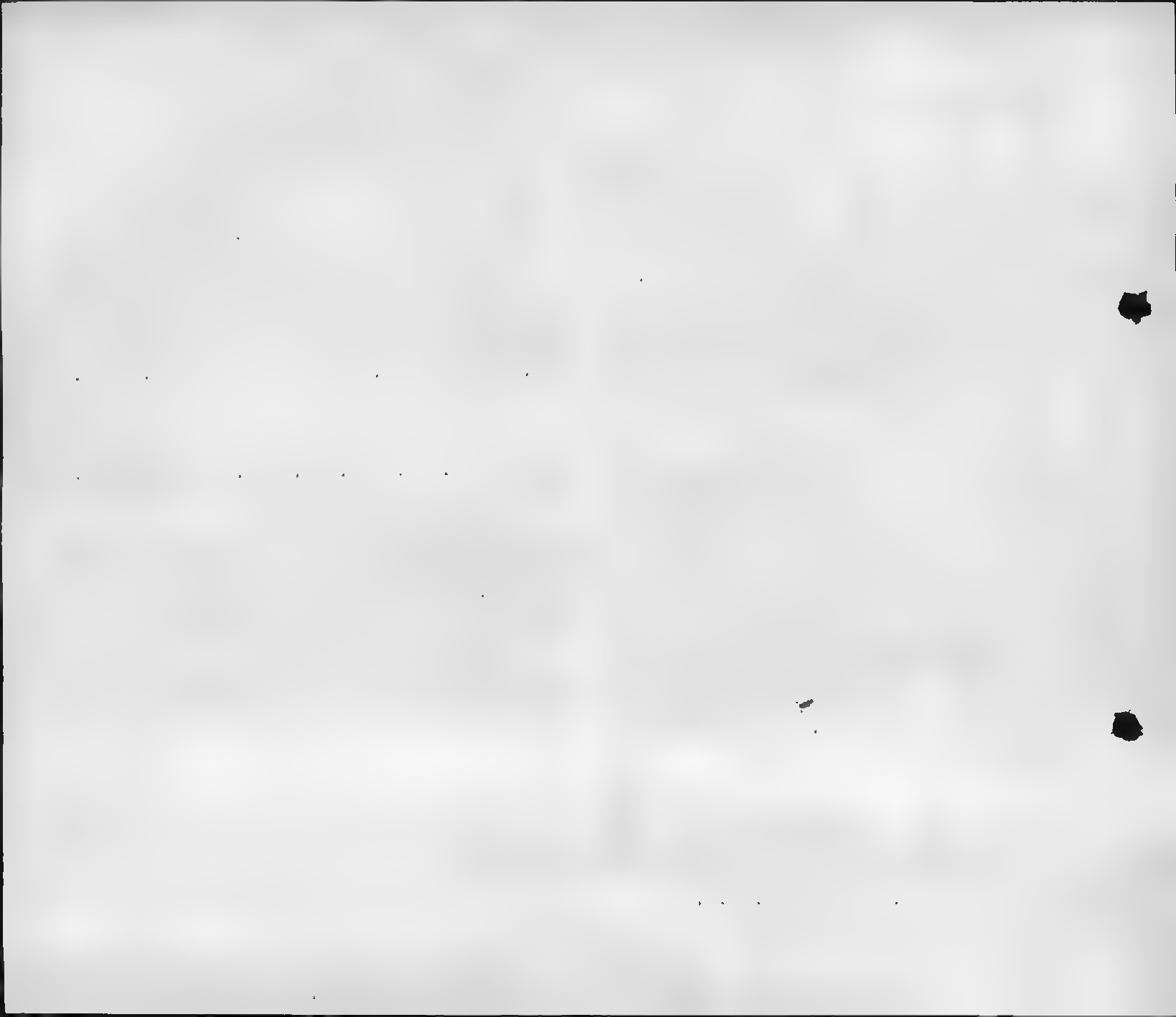
CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1 PLACE OF DEATH COUNTY <b>BALTIMORE</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>FORT HOWARD</b> LENGTH OF STAY (In this place) <b>119 DAYS</b>		2 USUAL RESIDENCE (HOME) OF DECEASED. STATE <b>MARYLAND</b> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>BALTIMORE</b> STREET ADDRESS (If rural give location) <b>1115 MADISON AVENUE</b>	
3. NAME OF DECEASED (Type or Print) <b>HOWARD E. BROWN</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>JULY 25 1955</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. SINGLE MARRIED, WIDOWED, DIVORCED. (Specify): <b>MARRIED</b>	8. DATE OF BIRTH: <b>1/18/11</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ASH MAN</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>GAS &amp; ELECTRIC CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>CONCORD, N. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN BROWN</b>		14. MOTHER'S MAIDEN NAME <b>JINNIE EURY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>YES</b> (If Yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>217-09-4293</b>	
17. INFORMANT & ADDRESS. <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		18. MEDICAL CERTIFICATION	
19A. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>473X</b> IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>15 MONTHS</b> <b>18 MONTHS</b>	
19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>MAR. 28, 1955</b> , to <b>JULY 25, 1955</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above. SIGNATURE <b>WILLIAM B. VANDEGRIFT, M.D.</b> ADDRESS <b>M. D. VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>7-26-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b> DATE THEREOF <b>8/1/55</b>		NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b> LOCATION (City, town, or county) <b>BALTIMORE, MARYLAND</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>CHARLES R. LAW</b> FUNERAL DIRECTOR ADDRESS <b>MORTUARY, 802-04 MADISON AVE. BALTIMORE, 1, MD.</b>	



6290

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO. CO.</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CHATONSVILLE</u>		STATE <u>MD</u> COUNTY <u>BALTO. 29</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. 29</u>	
OR TOWN <u>CHATONSVILLE</u>		LENGTH OF STAY (in this place) <u>1 yr</u>		STREET ADDRESS (If rural give location) <u>220 MALLOW HILL</u>		3401-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 RIDGEWAY MANOR</u>							
3. NAME OF DECEASED: (First) <u>JENNIE</u> (Middle) <u>BRYAN</u> (Last) <u>BRYAN</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>7/1/55</u> 19 <u>55</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE MARRIED WIDOWED DIVORCED <u>Single</u>		8. DATE OF BIRTH <u>2/14/1864</u>	
9. AGE last birthday <u>91</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Ind</u>			
13. FATHER'S NAME <u>JAMES BRYAN</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE MEARS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>1</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Ind</u>			
17. INFORMANT & ADDRESS: <u>Mrs. William Hall, 220 Mallow Hill</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Myocardial failure</u>						72 hours	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic CVD</u>						Unknown	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Sexual insacc. left hemiplegia</u>						1 year	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 16, 1954</u> to <u>July 1, 1955</u> , that I last saw the deceased alive on <u>June 30, 1955</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stephen L. Hargness</u>		M. D. <u>Curtis</u>		DATE SIGNED <u>7-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7/5/55</u>		NAME OF CEMETERY OR CREMATORY <u>LOU DON PARK</u>		LOCATION (City, town, or county) <u>BALTO. MD</u> (State)	
DATE REC'D BY LOCAL REGISTRAR <u>JUL 4 1955</u>		REGISTRAR'S SIGNATURE <u>B W Laumann</u>		FUNERAL DIRECTOR <u>THE MATH &amp; SON</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18-2A OVERVIEW

2

18-2A



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06279

6291

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> — MARYLAND				STATE <u>MD</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL) OR TOWN <u>Cockeysville Md</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodstock Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 W. Masonic Home</u>				STREET ADDRESS (If rural give location) <u>Old Court Rd. 1<sup>st</sup> X-3</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>David Newton Bence</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>July 8 1955</u>			
5. SEX. <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE—MARRIED, WIDOWED—DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Aug 18-1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Salesman</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Retail Merchants</u>			
11. BIRTHPLACE (State or foreign country): <u>Baltimore Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>Life</u>			
13. FATHER'S NAME: <u>David Bence</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Dial</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Laura M. McVicker</u>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral accident</u>						1 Month	
ANTECEDENT CAUSE (B) <u>Intoxic-taxis</u>						!	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-20</u> , 19 <u>53</u> to <u>July 8</u> , 19 <u>55</u> that I last saw the deceased alive on <u>July 8</u> , 19 <u>55</u> and that death occurred at <u>8:25</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Lees</u>		ADDRESS <u>Cockeysville Md</u>		DATE SIGNED <u>July 8/55</u>		M.D. <u>W. T. Lees</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>7-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Green Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-13-55</u>		REGISTRAR'S SIGNATURE <u>J. M. McVicker</u>		24. FUNERAL DIRECTOR <u>Wm. W. St. Paul &amp; Son</u>		ADDRESS <u>St. Paul &amp; Son</u>	

12/15/54

12/15/54

12/15/54

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06280

6292

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
X TOWN <u>Lodge Forest</u>				STREET ADDRESS (If rural give location) <u>130, S. Monroe St.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2549 Lodge Forest Drive</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Mary A. Burke</u>				<u>July 14/55 19</u>			
5. SEX. <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH: <u>May 2, 1883</u>	
9. AGE last birthday <u>72</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N.W.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>John Beyer</u>				14. MOTHER'S MAIDEN NAME: <u>Catherine Bentz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS: <u>Mrs. Mildred Lober, Pasadena, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>443X</u>							
ANTECEDENT CAUSE (B) <u>Hypertensive Pneumonia</u>						<u>3 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Hypertension C-V. Disease.</u>						<u>3 yrs.</u>	
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb.</u> , 19 <u>55</u> , to <u>July 14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 14</u> , 19 <u>55</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James G. Munroe</u>		M.D. <u>520 D St. Baltimore</u>		DATE SIGNED <u>7/16/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 18/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Olivet</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/18/55</u>		REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Harry F. Hitt</u>		ADDRESS <u>4101 Edmondson Ave</u>	



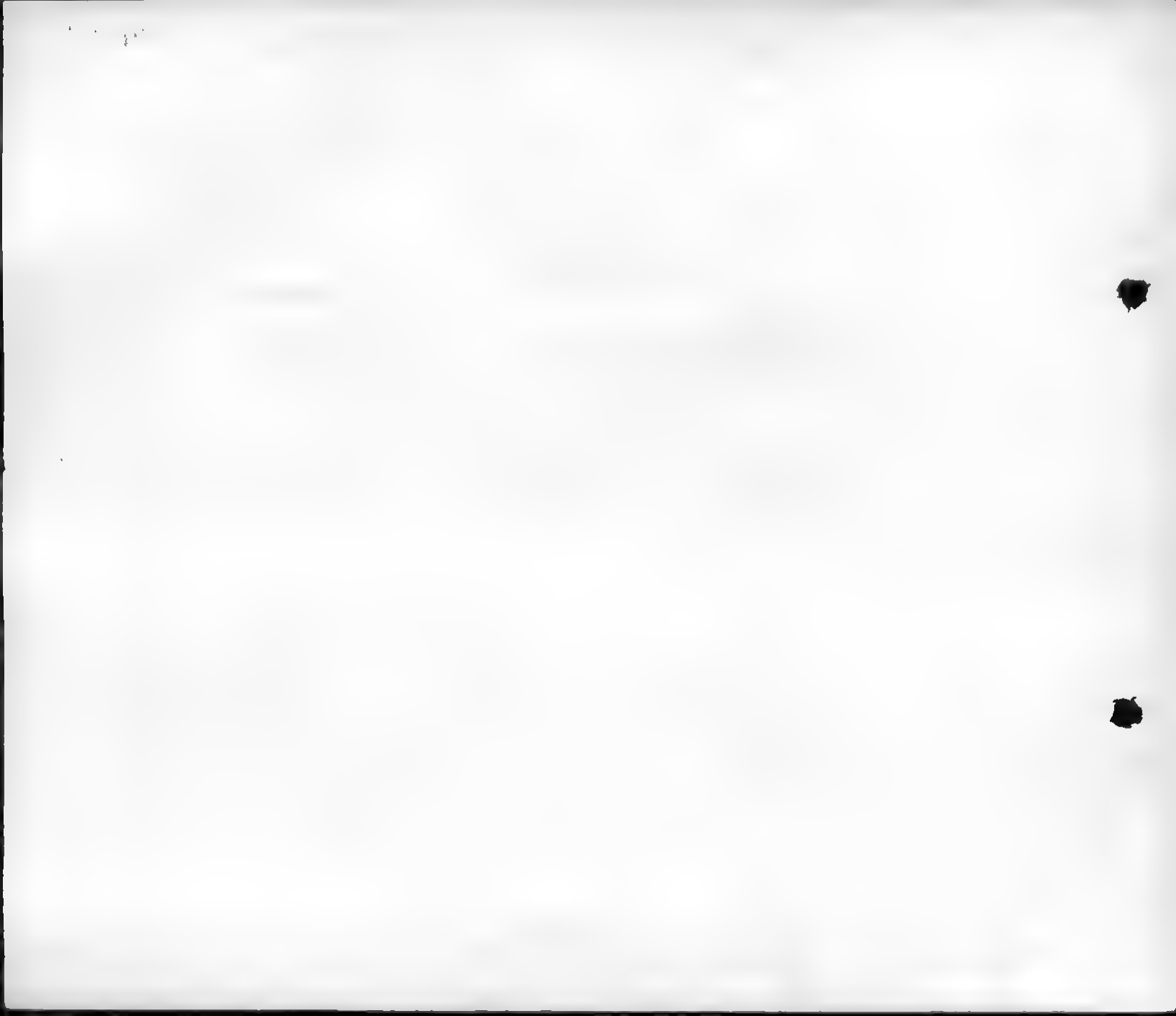
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Balts</u> CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Lutherville</u> OR TOWN <u>Lutherville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Caton Ridge Nursing Home</u>		STREET ADDRESS (If rural give location) <u>Broadway Road</u>	
3. NAME OF DECEASED: (Type or Print) <u>Harry Robert Burnham</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 26 - 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>Mar 25 - 1882</u>
9. AGE last birthday: <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Army</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>	
11. BIRTHPLACE (State or foreign country): <u>Balts MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Elijah F. Burnham</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Ann Lee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT'S ADDRESS: <u>Harry L. Burnham 848 Abbott St Baltimore 2</u>			
III. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Cerebral Embolus</u>			<u>13 hrs</u>
ANTECEDENT CAUSE (B) <u>arteriosclerotic cardiovascular disease</u>			<u>4-5 yrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>1954</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Amputation left leg - arteriosclerotic gangrene</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct.</u> , 19 <u>54</u> , to <u>26 July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>25 July</u> , 19 <u>55</u> , and that death occurred at <u>3:15 A.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>John H. Harris Jr.</u>		ADDRESS <u>1118 St Paul St, Balt. 2, Md</u>	
DATE SIGNED <u>7-26-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF <u>July 28 - 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore Baptist</u>		LOCATION (City, town, or county) (State) <u>Lutherville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-27-55</u>		REGISTRAR'S SIGNATURE <u>John Burnham</u>	
24. FUNERAL DIRECTOR <u>John Burnham</u>		ADDRESS <u>1118 St Paul St, Balt. 2, Md</u>	



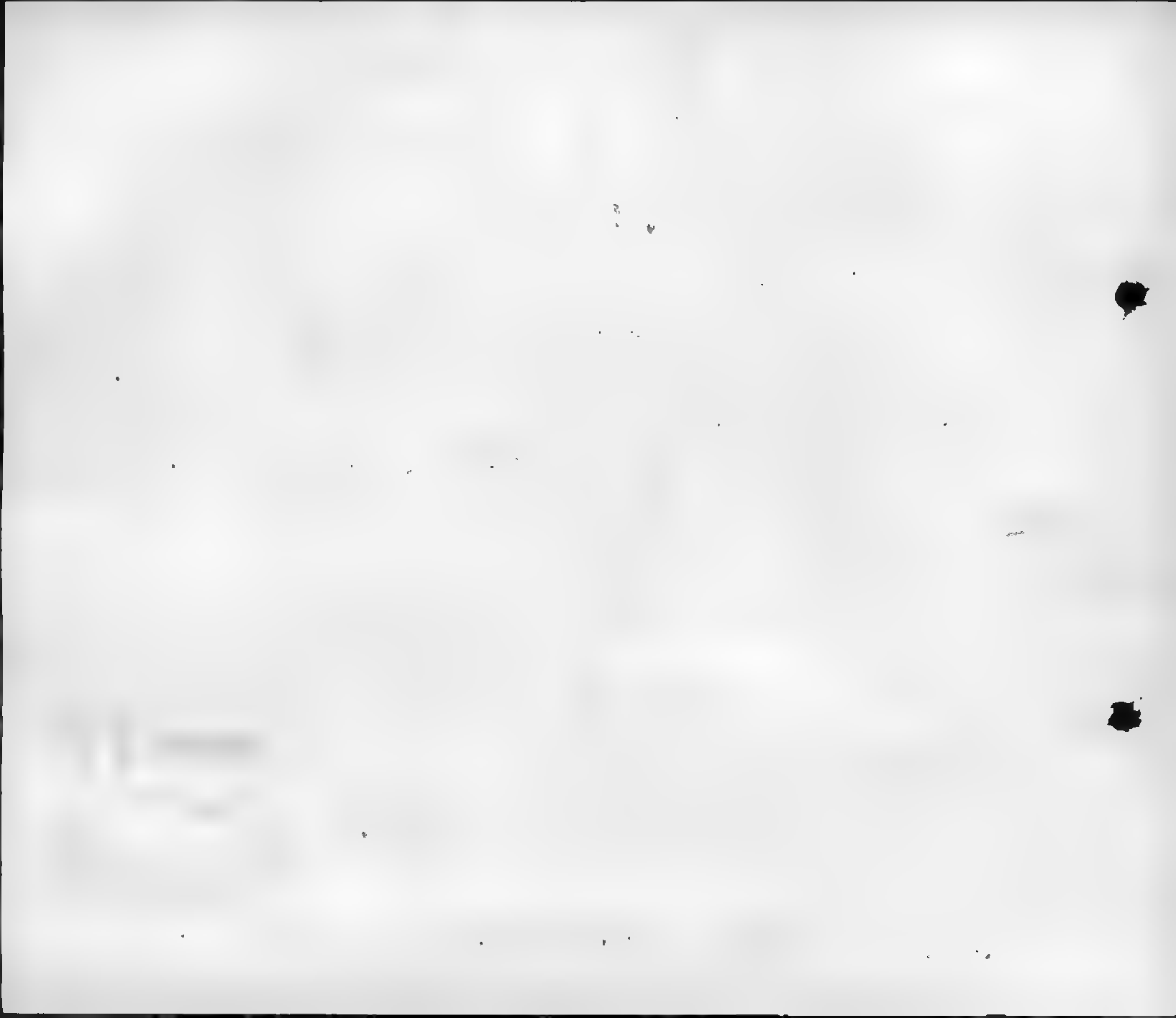
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06782  
6294  
CERTIFICATE OF DEATH  
Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTO. CO.</b>	MARYLAND	STATE <b>MD</b>	COUNTY <b>BALTO.</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>52 CATONSVILLE</b>	LENGTH OF STAY (in this place) <b>LIFE</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>52 CATONSVILLE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00 632 FREDK. AVE</b>		STREET ADDRESS (If rural give location) <b>632 FREDK. AVE.</b>	
3. NAME OF DECEASED (First) (Middle) (Last) <b>ANDREW G. BUSCHMANN</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>7/31/55</b>	
5. SEX: <b>M</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>SINGLE</b>	8. DATE OF BIRTH: <b>7/15/1918</b>
9. AGE last birthday: <b>37</b> yrs.		10. BIRTHPLACE (State or foreign country): <b>MD</b>	
11. BIRTHPLACE (State or foreign country): <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>FRANK BUSCHMANN</b>		14. MOTHER'S MAIDEN NAME: <b>SKICKE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.): <b>NO</b>		16. SOCIAL SECURITY NO. <b>954</b>	
17. INFORMANT & ADDRESS: <b>John Buschmann ST. AGNES LA.</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Myocardial infarction</b>		<b>2-6 hrs.</b>	
ANTECEDENT CAUSE (B) <b>None</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <b>None</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 29, 1955</b> , to <b>August 1, 1955</b> that I last saw the deceased alive on <b>July 29, 1955</b> and that death occurred at <b>MD</b> , from the causes and on the date stated above.			
SIGNATURE <b>Max Rath-Hon</b>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>8/3/55</b>	
NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>		LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
DATE REC'D BY LOCAL REGISTRAR <b>8-1-55</b>		REGISTRAR'S SIGNATURE <b>T.E. Harvey</b>	
24. FUNERAL DIRECTOR <b>Max Rath-Hon</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 186283  
6295 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u>	LENGTH OF STAY (in this place) <u>(1)</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>(6)</u>	TOWN <u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4129 Martin Ave</u>		STREET ADDRESS (If rural give location) <u>4129 Martin Ave</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>Caroline C. 1940</u>		OF DEATH: <u>July 11 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>	8. DATE OF BIRTH: <u>June 21st 1878 - 77 yrs</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	11. BIRTHPLACE (State or foreign country): <u>Balto. Md.</u>
13. FATHER'S NAME: <u>Frank A. Kelley</u>		14. MOTHER'S MAIDEN NAME: <u>Mary K. (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		17. INFORMANT'S ADDRESS: <u>John F. Otto 5006 Gwynndale Ave.</u>	
16. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>4500</u>			
ANTECEDENT CAUSE (B) <u>Generalized arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>hypertension, myocardial infarction</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6:11</u> , 1955 to <u>7:11</u> , 1955, that I last saw the deceased alive on <u>7/8</u> , 1955, and that death occurred at <u>5:15</u> M, from the causes and on the date stated above.			
SIGNATURE <u>James E. H.D.</u>		DATE SIGNED <u>7/13/55</u>	
M.D. <u>James E. H.D.</u>		ADDRESS <u>4129 Martin Ave.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7/14/55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>		LOCATION (If C., town, or county) <u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-13-55</u>		REGISTRAR'S SIGNATURE <u>A.W. Hedrich</u>	
24. FUNERAL DIRECTOR <u>Wm. Boll Inc. 1217 St. Paul St.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6261

06284

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 12000

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>1</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Lansdowne</u>	LENGTH OF STAY (in this place) <u>5 yrs</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Lansdowne</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3rd + Hollins Ferry Rd. Mt Zion Pk</u>		STREET ADDRESS (If rural, give location) <u>230 Hazel Ave</u>	
3. NAME OF DECEASED: (Type or Print) <u>Kent</u> <u>S.</u> <u>Callan</u>		4. DATE OF DEATH (Month) <u>7</u> (Day) <u>31</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Single</u>	8. DATE OF BIRTH: <u>12/21/1939</u>
9. AGE last birthday: <u>15</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>10</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>School Boy</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>St. Clements School</u>	
11. BIRTHPLACE (State or foreign country): <u>Johnstown Pa.</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>George H. Callan</u>		14. MOTHER'S MAIDEN NAME: <u>Rose M. Rice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY No.: <u>-</u>	
17. INFORMANT & ADDRESS: <u>Mr. George H. Callan</u>		<u>230 Hazel Ave</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
929.8 Immediate cause DUE TO (a) <u>Drowning (accidental)</u>		<u>24 hrs.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO (b) <u>-</u> stating underlying cause last (c) <u>-</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>			
19a. DATE OF OPERATION: <u>9 Nov.</u>		19b. MAJOR FINDING OF OPERATION: <u>None</u>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Swimming pool</u>	21c. (City or town) <u>Lansdowne</u> (County) <u>Balt.</u> (State) <u>Md.</u>	21d. TIME (Month) (Day) (Year) (Hour) <u>7-3-55</u> <u>6:30 PM</u>
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Went swimming</u>		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>A. L. Caplin</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>7-4-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>7/6/55</u>	NAME OF CEMETERY OR CREMATORY: <u>New Cathedral Cem.</u>	
LOCATION (City, town, or county): <u>4300 Old Frederick Rd.</u>	(State) <u>Md.</u>		
DATE REC'D BY LOCAL REG. <u>July 5, 1955</u>	RE: <u>M. R. Hedrick</u>	24. FUNERAL DIRECTOR: <u>John J. Lowan &amp; Son</u>	
ADDRESS: <u>20 Hollins St.</u>		<u>SE</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2, 2. Caples

6 Harbour Rd.

Riverview Town, N.Y.

## 6296 CERTIFICATE OF DEATH

Reg. Dist. No. 33

## I. PLACE OF DEATH:

COUNTY **Baltimore** MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) **Owings Mills** LENGTH OF STAY (in this place) **3 years**  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **Rosewood Training School**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town) **Baltimore City**  
 TOWN **3001-4**  
 STREET ADDRESS (If rural, give location) **261 Dallas Court**

## 3. NAME OF DECEASED:

(First) **Susan** (Middle) **Ann** (Last) **Campbell**

4. DATE OF DEATH: (Month) **7** (Day) **23** (Year) **19 55**

## 5. SEX:

**female**

6. COLOR OR RACE: **white**

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **single**

## 8. DATE OF BIRTH:

**4/1/47**

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.  
**8** yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **---**

10b. KIND OF BUSINESS OR INDUSTRY: **---**

11. BIRTHPLACE (State or foreign country): **Maryland**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

## 13. FATHER'S NAME:

**Raymond Campbell**

## 14. MOTHER'S MAIDEN NAME:

**Josephine Zahradka**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) **---**

16. SOCIAL SECURITY No.: **---**

## 17. INFORMANT &amp; ADDRESS:

**Rosewood Records, Owings Mills, Maryland**

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

756.2  
 Immediate cause

(a) **Intestinal Obstruction**

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) **Congenital Atresia of the Esophagus (Jeguno**

DUE TO

(c) **Esophageal Anaestomosis—Post operative—7/20/47—esophagus, /**

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

**4/4/47—Thoractomy; 6/20/47—jejunojejunostomy**

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

**Congenital lesion basal ganglion (athetosis)**

INTERVAL BETWEEN ONSET AND DEATH

**1 1/2 days**

**birth**

**Jejunum/ anastomosis**

20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7/20** 19 **55** to **7/23** 19 **55**, that I last saw the deceased alive on **7/23** 19 **55**, and that death occurred at **8:50 a.m.**, from the causes and on the date stated above.

SIGNATURE

**Harry S. Butler**

(DEGREE OR TITLE) ADDRESS

**M.D. Owings Mills Maryland**

DATE SIGNED

**7/25/55**

## 23. BURIAL/CREMATION REMOVAL (Specify):

**BURIAL**

DATE/THEREOF

**7-27-55**

NAME OF CEMETERY OR CREMATORY

**BALTIMORE CEM**

LOCATION (City, town, or county)

**BALTO. MD**

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

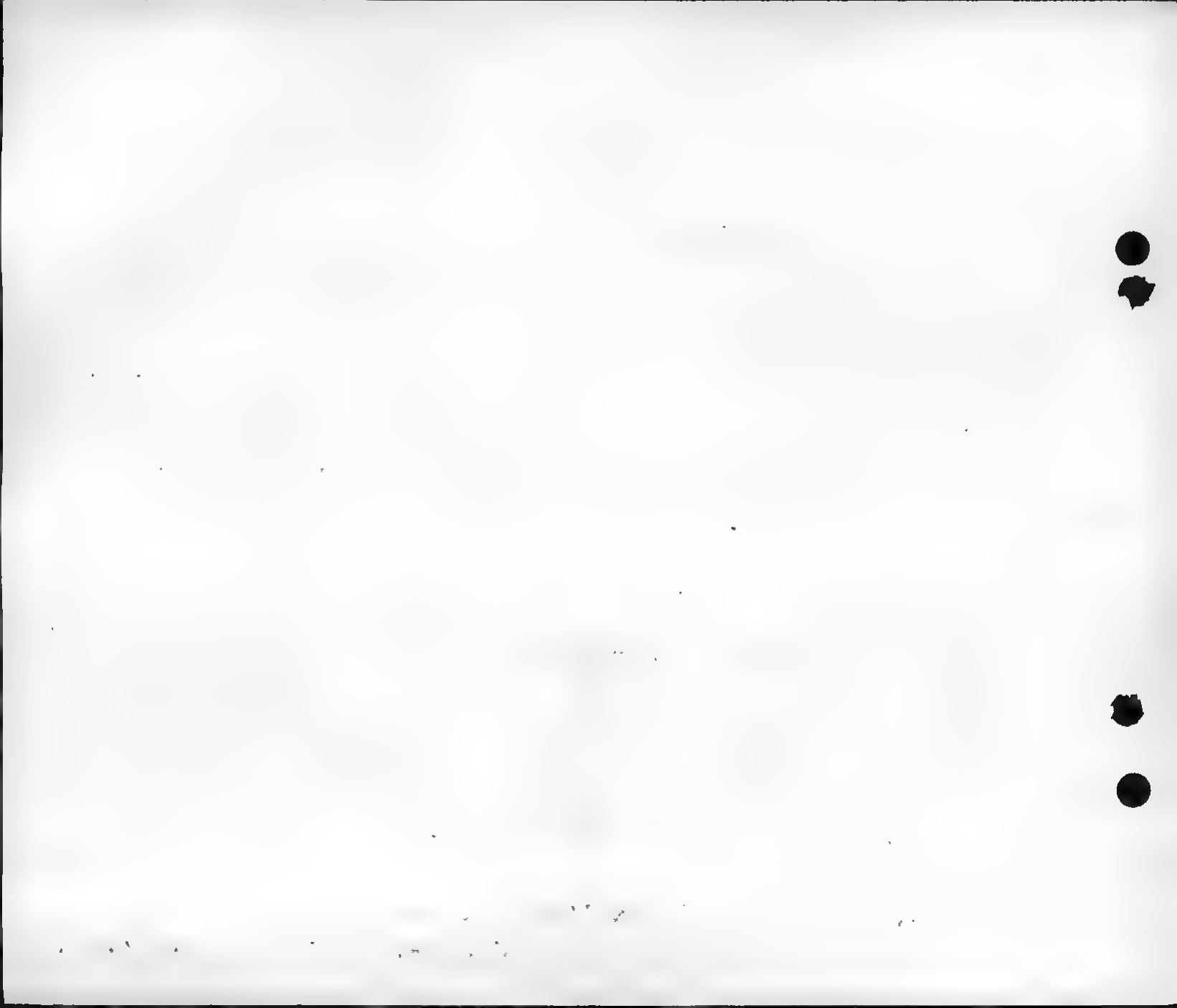
24. FUNERAL DIRECTOR

**MR. CVACH-SON 900 N. CHESTER ST**

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

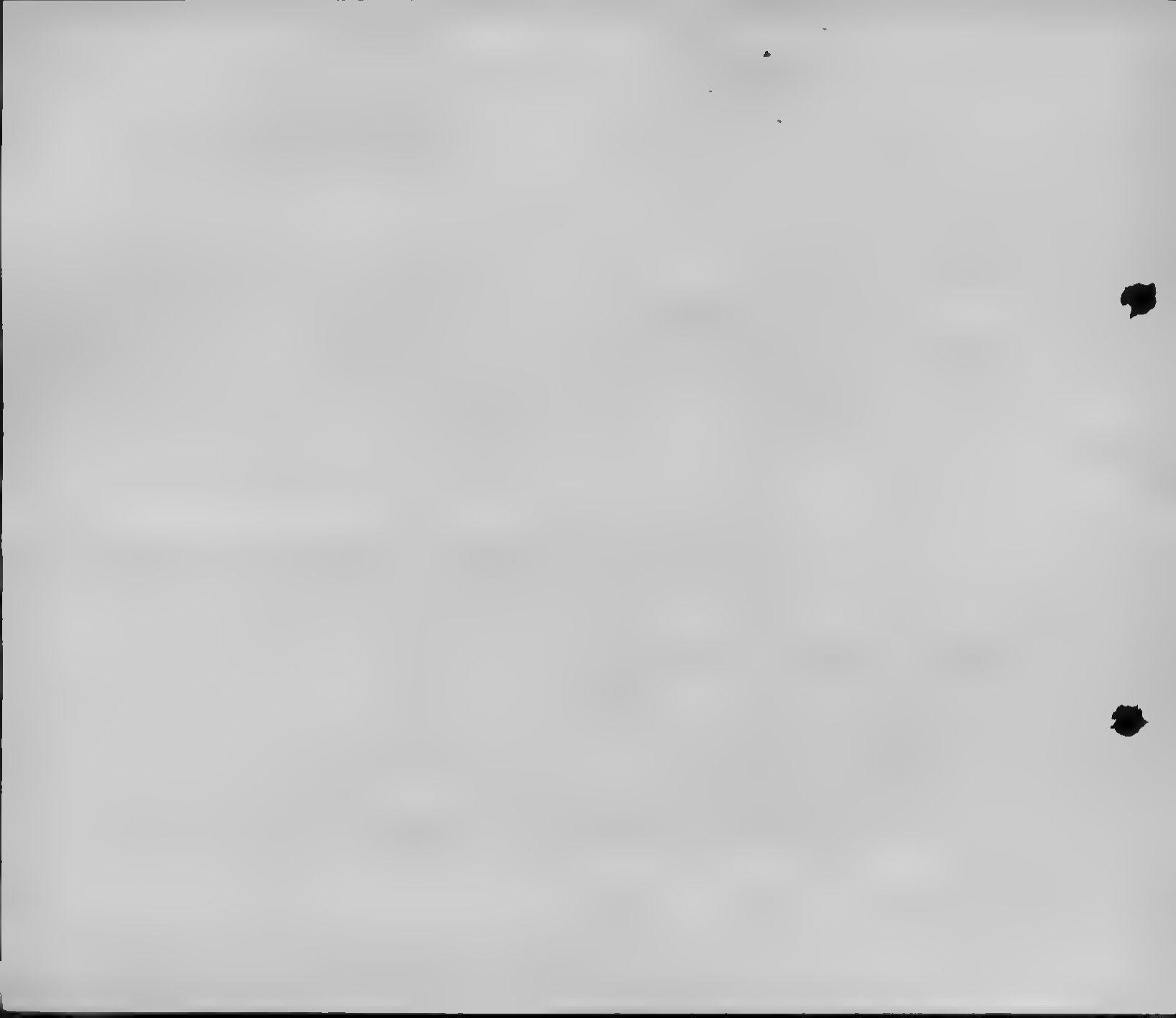
Reg. Dist.

No.

<b>1. PLACE OF DEATH:</b> COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Baltimore</u> LENGTH OF STAY (In this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bethlehem Steel Co.</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>632 Cheraton Road</u>											
<b>3. NAME OF DECEASED:</b> (First) <u>LUTHER</u> (Middle) <u>CARAWAY</u> (Last) (Type or Print)				<b>4. DATE OF DEATH</b> (Month) <u>July</u> (Day) <u>7</u> (Year) <u>19 55</u>											
<b>5. SEX:</b> <u>Male</u>		<b>6. COLOR OR RACE:</b> <u>Colored</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED:</b> <u>MARRIED</u>		<b>8. DATE OF BIRTH:</b> <u>10/23/01</u>		<b>9. AGE last birthday:</b> <u>53</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <u>Laborer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <u>Bethlehem Steel Co.</u>				<b>11. BIRTHPLACE</b> (State or foreign country): <u>North Carolina</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME:</b> <u>Luther Caraway</u>						<b>14. MOTHER'S MAIDEN NAME:</b> <u>Rosie</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY No.:</b>				<b>17. INFORMANT &amp; ADDRESS:</b> <u>Alice B. Caraway 632 Cheraton Road</u>							
<b>18. MEDICAL CERTIFICATION</b>															
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b> <u>443X</u> Immediate cause (a) <u>Hypertensive cardiovascular disease</u> DUE TO Antecedent cause(s) (b) ..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> .....					
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH</b>															
<b>19a. DATE OF OPERATION:</b>				<b>19b. MAJOR FINDING OF OPERATION:</b>											
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY</b>				<b>21c. (City or town) (County) (State)</b>							
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>				<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>				<b>21f. HOW DID INJURY OCCUR?</b>							
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b> SIGNATURE <u>[Signature]</u> M. D. <u>[Signature]</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>July 7, 1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>															
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <u>Burial</u>				<b>DATE THEREOF</b> <u>7/12/55</u>				<b>NAME OF CEMETERY OR CREMATORY</b> <u>Wadesboro</u>				<b>LOCATION (City, town, or county) (State)</b> <u>North Carolina</u>			
<b>DATE REC'D BY LOCAL REG.</b> <u>8-11</u>				<b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>				<b>24. FUNERAL DIRECTOR</b> <u>Clara D. Lively</u>				<b>ADDRESS</b> <u>661 W. Barre Street</u>			

06285

6297





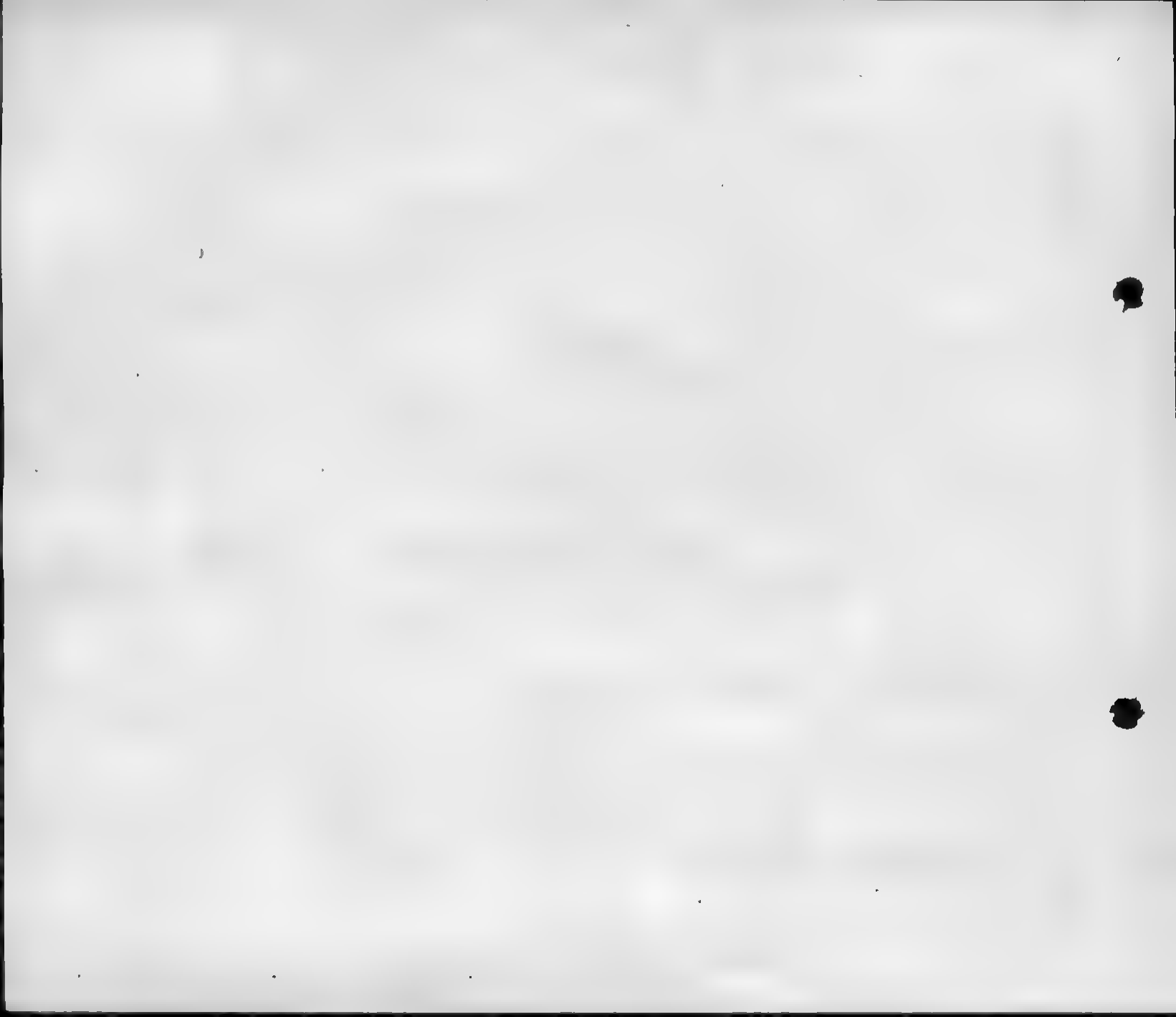
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6298  
CERTIFICATE OF DEATH

06288

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Lancaster</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard, Md.</u>		<u>41</u> days		OR TOWN <u>Baltimore</u> <u>22</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>8000 Kavanaugh Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>LAWRENCE A. CASWELL</u>				OF DEATH: <u>July 24</u> <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>8/5/27</u>	
9. AGE last birthday: <u>27</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Bass Lake, Minn.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. IF UNDER 24 HRS. Months Days Hours Min.	
13. FATHER'S NAME: <u>Earl Caswell</u>				14. MOTHER'S MAIDEN NAME: <u>Cora Wilkinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes WW II</u>				16. SOCIAL SECURITY NO. <u>466-26-0108</u>			
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
<u>430.0</u>				<u>3 MONTHS</u>			
IMMEDIATE CAUSE				(A) <u>AORTIC INSUFFICIENCY</u>			
ANTECEDENT CAUSE (S)				DUE TO <u>DESTRUCTION OF AORTIC VALVE BY BACTERIAL</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>ENDOCARDITIS</u>			
				DUE TO			
				(C)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JUNE 13, 1955</u> , to <u>JULY 24, 1955</u> , and that death occurred at <u>3:05A</u> M. from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandegrift, M.D.</u>				ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>7-25-55</u>			
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY) <u>Burial</u> <u>7-28-55</u>				NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)			
DATE REC'D BY LOCAL REGISTRAR				24. FUNERAL DIRECTOR <u>Wm. Cook-Blight, Inc. 6009 Harford Rd. Baltimore 14, Maryland</u> ADDRESS			



6293

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Ma-</u> COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	LENGTH OF STAY (If at this place) <u>5 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Randalltown</u>	
OR TOWN <u>52</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove</u>		STREET ADDRESS (If rural give location) <u>Liberty Road</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>Thomas Nathan Carey</u>	(Middle) (Last) <u>Ca</u>	DATE OF DEATH <u>7 31 1955</u>	
5. SEX. <u>M</u>	6. COLOR OR RACE. <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>S</u>	8. DATE OF BIRTH: <u>10/26/19?</u>
		9. AGE last birthday <u>85</u> yrs.	10. AGE UNDER 1 YEAR: <u>3</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Mason Building</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Va -</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Reuben Carey</u>		14. MOTHER'S MAIDEN NAME: <u>May Straloch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>450.0</u>		<u>?</u>	
ANTECEDENT CAUSE (B)		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		<u>?</u>	
(A) <u>Arterio-sclerotic heart disease</u>			
(B) <u>Advanced Arteriosclerosis</u>			
(C) <u>Senility</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>-</u>		19B. MAJOR FINDINGS OF OPERATION: <u>-</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) <u>1</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/25/55</u> , to <u>7/31/55</u> , that I last saw the deceased alive on <u>7/31/55</u> , and that death occurred <u>5:26 P.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Charles Ward M.D.</u>		DATE SIGNED <u>7/31/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 2 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>		LOCATION (City, town, or county) (State) <u>Randalltown Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/2/55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	
FUNERAL DIRECTOR <u>Willis Lawson</u>		ADDRESS <u>4510 Liberty Heights Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

06290

63 '0

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines</u>		STREET ADDRESS (If rural, give location) <u>1915 Gwynno Falls Pkwy.</u>	
3. NAME OF DECEASED (First) <u>Louis</u> (Middle) (Last) <u>Cohen</u>		4. DATE OF DEATH (Month) <u>7</u> (Day) <u>25</u> (Year) <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Poland</u>
13. FATHER'S NAME <u>Not Known</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>                    </u>	
17. INFORMANT AND ADDRESS <u>Rebecca Cohen - same</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>44 X</u> <u>Cerebral Thrombosis</u>		<u>2 da.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>?</u>
(a) <u>Chr. Hypertensive Cardio-Vascular System Disease</u>		<u>?</u>
(c) <u>Generalized arteriosclerosis</u>		<u>?</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-9, 1955, to 7-25, 1958, that I last saw the deceased alive on 7-25, 1958, and that death occurred at 1:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>7-26-1958</u>	<u>Washington Rd.</u>	<u>Balto</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>7-26-58</u>	<u>[Signature]</u>	<u>Fair Leurs Inc. 2100 Eutaw Place</u>		

MARGIN RESERVE FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 6301 CERTIFICATE OF DEATH

Reg. Dist. No.

## I. PLACE OF DEATH:

COUNTY BALTO MARYLAND  
 CITY (If outside corporate limits, write RURAL) LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 TOWN STONELEIGH  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 500 STONELEIGH RD.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY BALTO.  
 CITY (If outside corporate limits, write RURAL, and give nearest town)  
 OR TOWN STONELEIGH (TOWSON)  
 STREET ADDRESS (If rural give location)  
500 STONELEIGH RD.

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
HANS W. CONSTADT

4. DATE OF DEATH (Month) (Day) (Year)  
AUG 2 1955

## 5. SEX:

M

6. COLOR OR RACE:  
W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):  
MARRIED

8. DATE OF BIRTH:  
APRIL 12, 1890

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR: IF UNDER 24 HRS.  
 Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:  
PHYSICIAN

10b. KIND OF BUSINESS OR INDUSTRY:  
MEDICAL

11. BIRTHPLACE (State or foreign country):  
GERMANY

12. CITIZEN OF WHAT COUNTRY?  
U.S.

## 13. FATHER'S NAME:

ERNST LUDWIG CONSTADT

## 14. MOTHER'S MAIDEN NAME:

MARTHA SCHLESINGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  
4 No

16. SOCIAL SECURITY No.:  
—

17. INFORMANT & ADDRESS:  
MRS. ELIZABETH J. CONSTADT ABOVE

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X  
 Immediate cause (a) ...  
DUE TO  
 Antecedent causes (s) (b) ...  
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO  
 (c)

Carcinoma of the Cecum  
= metastases

Interval Between Onset And Death

4 Mos. +

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

April 21, 1955 Carcinoma of Cecum = metastases to liver and

## 2. ACCIDENT SUICIDE HOMICIDE

(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December, 1950, to July 2, 1953, that I last saw the deceased

alive on July 1, 1955, and that death occurred at 6:35 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED  
W. Grafton Hensperger M.D. 214 Medical Art Bldg 7/3/55

23. BURIAL, CREMATION, REMOVAL (Specify) DATE HERE OF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State)  
BURIAL JULY 5, 1955 DRUID RIDGE RIKESVILLE MD

DATE RECD BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS  
— — H.W. JENKINS & SONS Co. 4905 YORK RD  
BALTO., MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FR HENRIGER



MARYLAND STATE DEPARTMENT OF HEALTH

6322

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

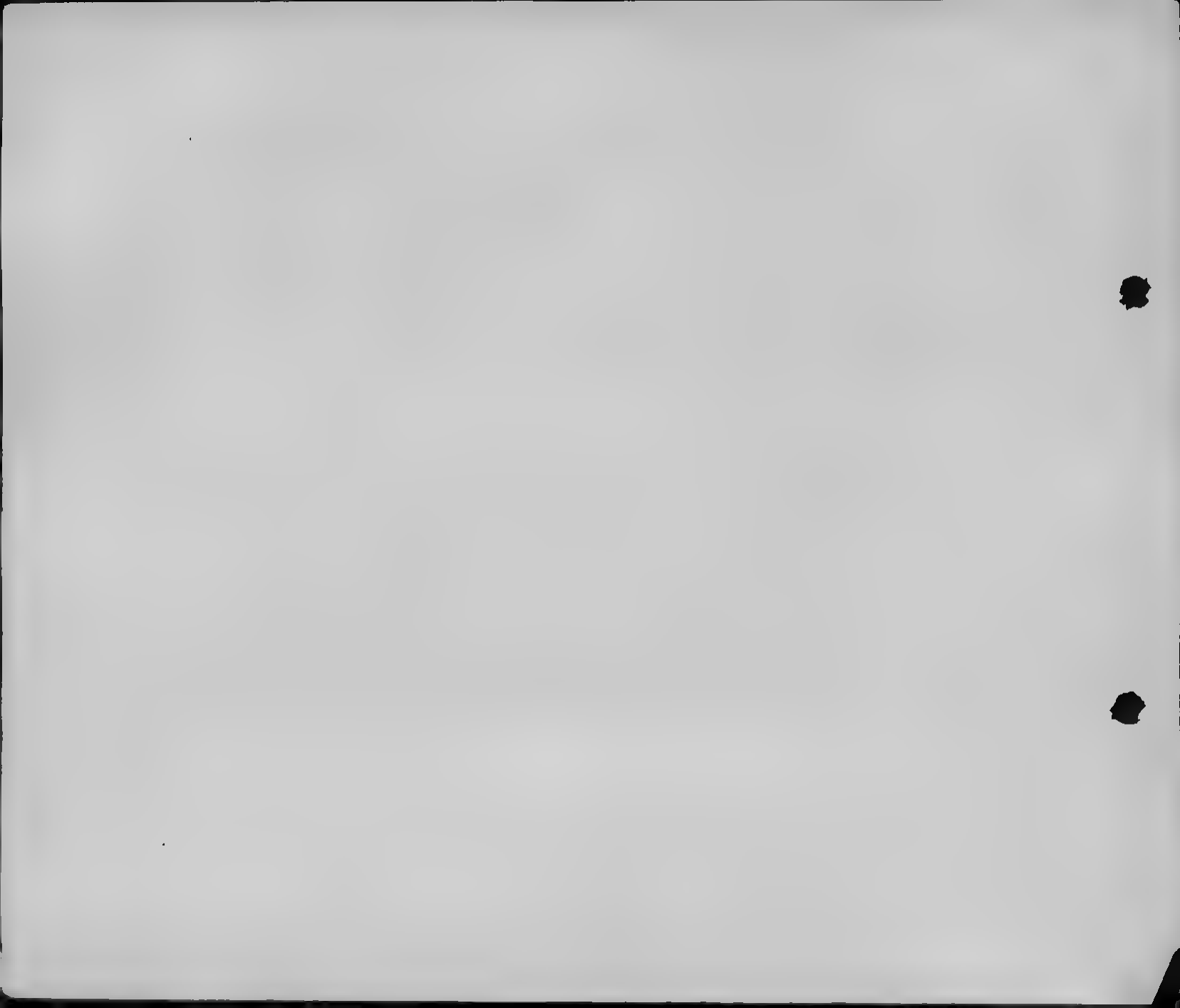
06292

Reg. Dist. No. 42

1. PLACE OF DEATH - COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baynesville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baynesville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>8303 Loch Raven Boulevard</b>		STREET ADDRESS (If rural, give location) <b>8003 Loch Raven Boulevard</b>	
3. NAME OF DECEASED (First) <b>LENA</b>	(Middle) <b>A.</b>	(Last) <b>COOK</b>	4. DATE OF DEATH (Month) <b>July</b> (Day) <b>15</b> (Year) <b>1955</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Aug. 23, 1872</b>
9. AGE last birthday <b>82</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Meeth</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Schreiber</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <b>Mrs. Lena A. Cook</b>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
<b>420.1</b> <b>Immediate cause (a) Coronary Thrombosis</b> <b>Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</b> <b>(c)</b>			<b>Sudden</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE OF DEATH PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory street, office bldg., etc.) OF INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <b>Charles E. Jonnell</b>		DATE SIGNED <b>7/19/55</b>	
DEGREE OR TITLE <b>Medical Examiner</b>		ADDRESS <b>1501 York Rd Towson Md 21204</b>	
23. FUNERAL DIRECTOR		ADDRESS	
<b>Wm. Cook, Inc.</b>		<b>1217 St. Paul Street</b>	
DATE RECEIVED BY LOCAL REG.		REGISTRAR'S SIGNATURE	
<b>7/24/55</b>		<b>Wm. Cook, Inc.</b>	

MARGIN RESERVED FOR FINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



639  
CERTIFICATE OF DEATH

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Catonsville, 57  
TOWN LENGTH OF STAY (in this place) 5 yrs.HOSPITAL OR (Shady Nook Nursing Home)  
INSTITUTION OR 90  
STREET ADDRESS 1002 N. Rolling Road

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore 34 14  
OR TOWNSTREET (If rural, give location)  
ADDRESS Roland Park Apts.

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Grace

M.

Cord

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

July 16,

19 55

## 5. SEX:

Female

## 6. COLOR OR RACE:

White

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Widow

## 8. DATE OF BIRTH:

June 16, 1873

## 9. AGE last birthday:

82 yrs.

## IF UNDER 1 YEAR

## IF UNDER 24 HRS.

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

Bedford, Pa.

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

Isaac Mengel

## 14. MOTHER'S MAIDEN NAME:

Lucinda Probasco

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Roderwood, Md.

Mr. George M. Mealy 8206 Bellona Ave.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1  
Immediate cause

(a)

Broncho - pneumonia

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

Cardio - Vascular Heart disease

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 days

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

Arteriosclerosis

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 19 35 to July 16, 19 55, that I last saw the deceased alive on July 16, 19 55, and that death occurred at 3 30 A.M. from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

7-22-55

Victor C. Harry

John O. Mitchell &amp; Sons Inc. 1900 Butaw Place

MARGIN RESERVED FOR BINDING



63-4

Items 13, 14 File 184 8-4-50 et

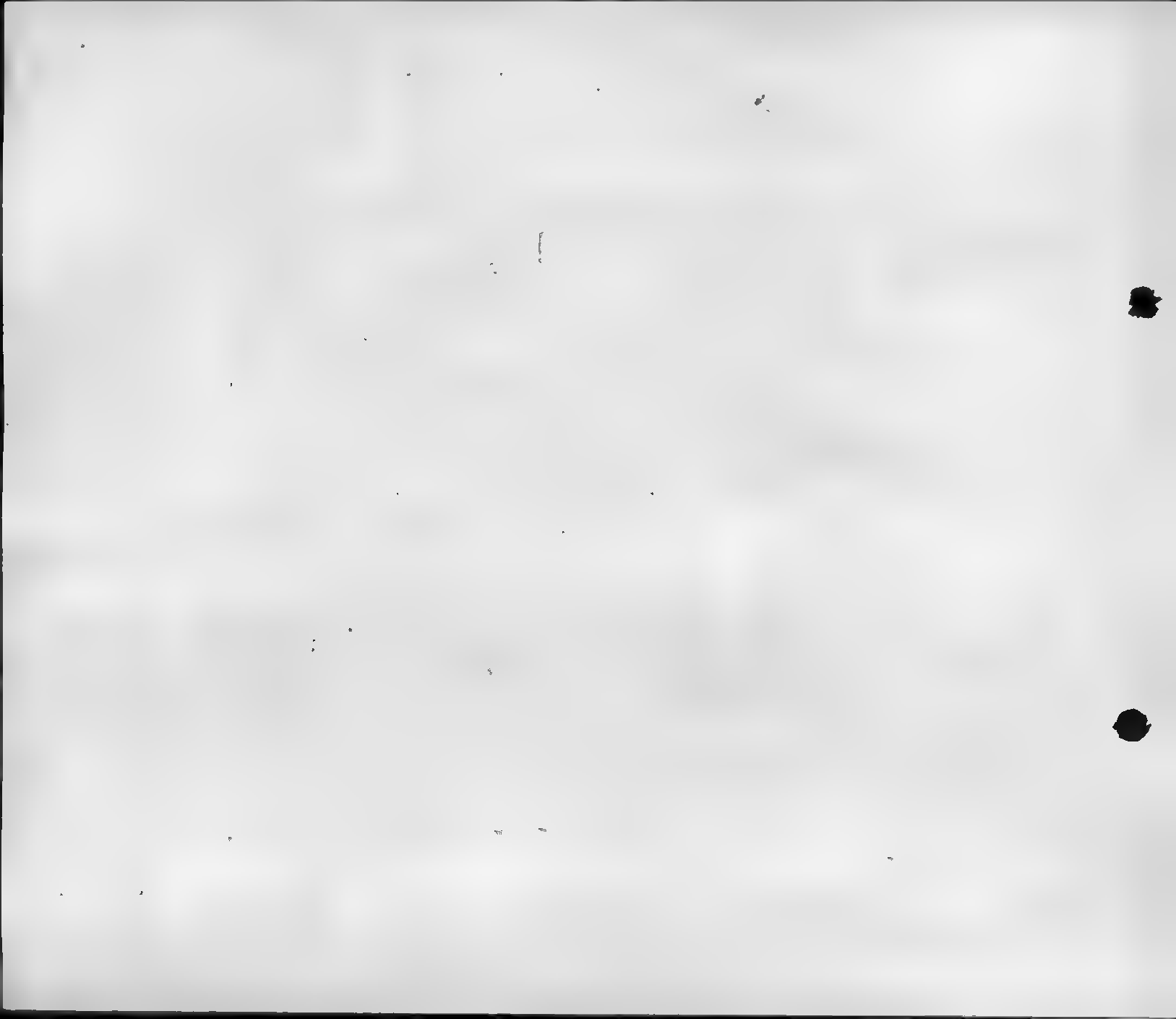
## CERTIFICATE OF DEATH

Reg. Dist. No. 36

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>1 week</u>	CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>34x10. 24 14</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Francis Nursing Home</u>		STREET ADDRESS (if rural give location) <u>711 St. Francis St.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>Richard</u>	(First) (Middle) (Last) <u>Costello</u>	OF DEATH <u>May 24th</u>	<u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>12/16/1874</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Plumber</u>	9. AGE last birthday <u>80 yrs</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>American</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Ruth Nass - 010 Clover Rd.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>450.0</u>		<u>46 H. 3</u>	
ANTECEDENT CAUSE (S) <u>None</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>			
19A. DATE OF OPERATION. <u>7-25-55</u>		19B. MAJOR FINDINGS OF OPERATION. <u>None</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE OLD INJURY OCCURRED? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-25</u> , 19 <u>55</u> to <u>8-25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7-29</u> , 19 <u>55</u> , and that death occurred at <u>10</u> M. from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>7-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Tourmal</u>	DATE THEREOF <u>12/55</u>	NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>	
LOCATION (City, town, or county) <u>Balto. Md.</u>	24. FUNERAL DIRECTOR <u>Wm. Cook &amp; Co. 121 St. Paul St.</u>		ADDRESS
DATE REC'D BY LOCAL REGISTRAR <u>8-1-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND

06295  
STATE DEPARTMENT OF HEALTH

6305

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH: COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Maryland</b> COUNTY <b>Balto</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>637 Murdock Road</b>		STREET ADDRESS (If rural, give location) <b>637 Murdock Road</b>	
3. NAME OF DECEASED (First) <b>Mr. Howard</b> (Middle) <b>Lee</b> (Last) <b>Cunningham</b>		4. DATE OF DEATH (Month) <b>July</b> (Day) <b>23rd</b> (Year) <b>55</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH <b>Jan. 31, 1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk, Oil</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <b>68</b> yrs. If under 1 year: Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.
11. FATHER'S NAME <b>George Cunningham</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. MOTHER'S MAIDEN NAME <b>Minnie Long</b>		14. INFORMANT AND ADDRESS <b>Mrs. Beatrice M. Cunningham, 637 Murdock</b>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <b>410X Rheumatic Heart Disease with Aortic &amp; Mitral Stenosis &amp; Insufficiency - ending in Chronic Congestive Heart Failure (3 yrs)</b>		<b>12 yrs +</b>	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<b>52 yrs</b>	
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>Rheumatic Fever @ age of 16</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>APR. 21, 1955</b> , to <b>JULY 23, 1955</b> , that I last saw the deceased alive on <b>JULY 22, 1955</b> , and that death occurred at <b>7 A. M.</b> , from the causes and on the date stated above.			
SIGNATURE <b>Robert W. Garis, M.D.</b>		ADDRESS <b>1103 St. Paul St Baltimore-2 Md.</b> DATE SIGNED <b>7/24/55</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE <b>July 26, 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REG. <b>2-25-55</b>		REGISTRAR'S SIGNATURE <b>Leonard J. Ruck</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, 5305 Harford Road #14</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

Dr. Garis  
Ambassador Apts. 39th & Canterburg  
or office 1103 St. Paul St. on Mon.



6306

CERTIFICATE OF DEATH

Reg. Dist. No.

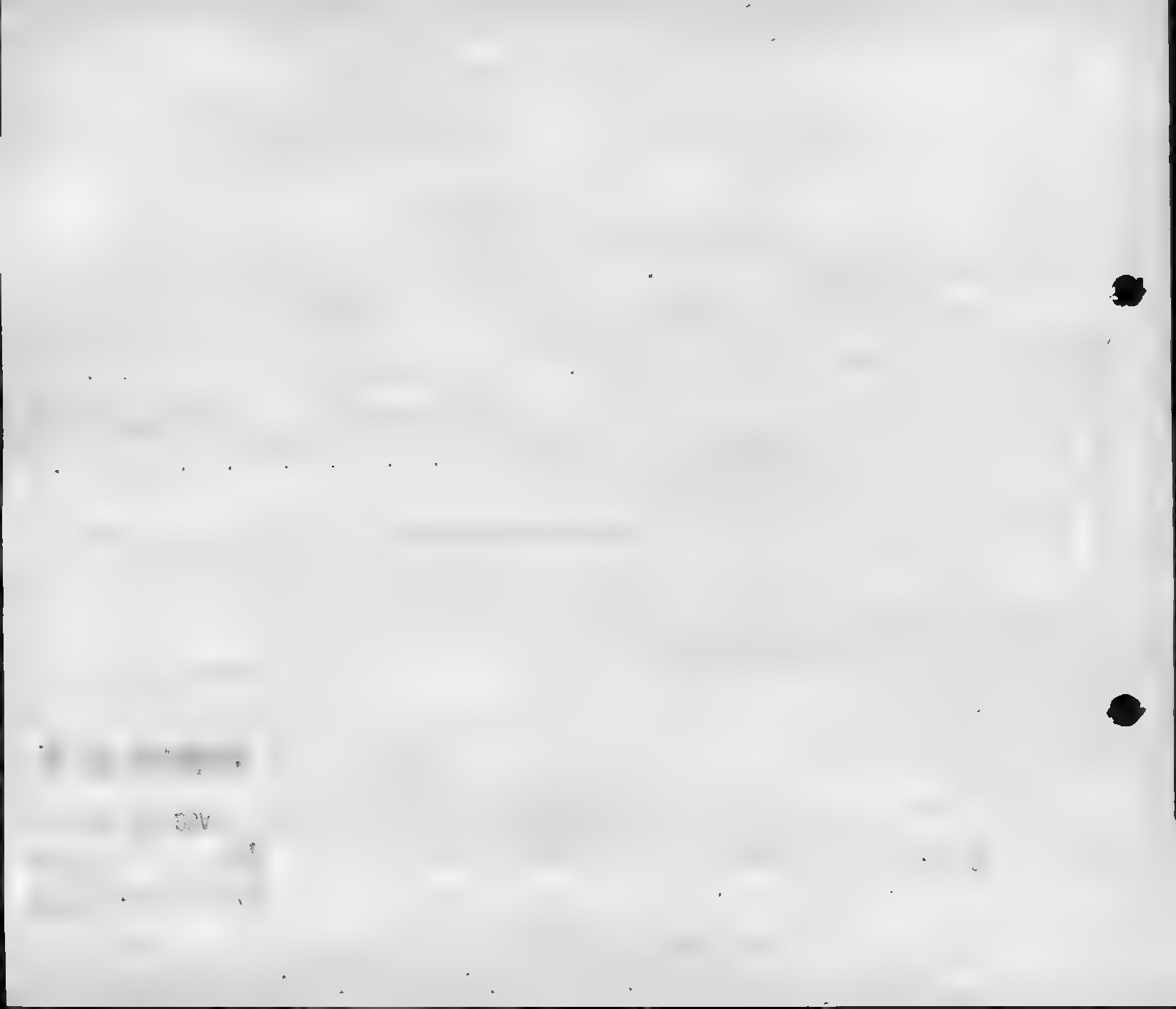
1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>MARYLAND</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>FORT HOWARD</b>	LENGTH OF STAY (in this place) <b>9 DAYS</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>BALTIMORE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>		STREET ADDRESS (If rural give location) <b>1407 WALKER AVENUE #12</b>	
3. NAME OF DECEASED (Type or Print) <b>EDWARD J. CZARNECKI</b>	First (Middle) (Last)	4. DATE OF DEATH <b>JULY 27 1955</b>	(Month) (Day) (Year)
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <b>MARRIED</b>	8 DATE OF BIRTH <b>10/14/22</b>
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>SALESMAN</b>	10B KIND OF BUSINESS OR INDUSTRY <b>DURFLEX CORP.</b>	9. AGE last birthday (If under 1 year, give months, days, hours, minutes) <b>32 yrs</b>	11 BIRTHPLACE (State or foreign country): <b>WILMINGTON, DELAWARE</b>
13 FATHER'S NAME <b>WILLIAM CZARNECKI</b>	14 MOTHER'S MAIDEN NAME <b>FLORENCE KRUPA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES KOREAN</b>	16 SOCIAL SECURITY NO <b>221-10-5275</b>	17. INFORMANT'S ADDRESS <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		UNKNOWN	
IMMEDIATE CAUSE (A) <b>151X CARCINOMA OF STOMACH</b>			
ANTECEDENT CAUSE (B) <b>DUE TO</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(C) <b>DUE TO</b>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B PLACE (Home, farm, factory, office bldg., etc.) OF INJURY	21C WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>JULY 18, 1955</b> , to <b>JULY 27, 1955</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.			
WILLIAM B. VANDEGRIFT, M.D.		M. D. VAH, FORT HOWARD, MARYLAND 7-28-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>	DATE THEREOF <b>7-28-55</b>	NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL CEMETERY</b> LOCATION (City, town, or county) <b>WILMINGTON, DELAWARE</b>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>10: STANLEY S. YASIK, INC. 616 S. Franklin St. BALTIMORE, MD.</b>		24. FUNERAL DIRECTOR ADDRESS <b>WM. COOK-BLIGHT, INC., 6009 HARFORD ROAD BALTIMORE, MD.</b>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

SHIPPED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06297  
Reg. Dist.

No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>md</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Grocers Quarter</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Water Gunpowder River</u>				STREET ADDRESS <u>1825 Edison Hwy.</u> (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) <u>Shester E. Danneberg</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 24 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>		8. DATE OF BIRTH: <u>July 27, 1904</u>	
9. AGE last birthday: <u>50</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Maintenance</u>		11. BIRTHPLACE (State or foreign country): <u>Balto. md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Albert Danneberg</u>				14. MOTHER'S MAIDEN NAME: <u>Virginia Hardesty</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>220-14-0910</u>		17. INFORMANT & ADDRESS: <u>Mrs. Virginia Danneberg 1825 Edison Hwy.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						<u>One week</u>	
Immediate cause (a) <u>Drowning (accidental)</u> DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 24 55 10A</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Boat turned over + sank</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>J. McCarraime MD</u>		M. D.		CHIEF MEDICAL EXAMINER		DATE SIGNED <u>7/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REG. <u>7/27/55</u>		REGISTRAR'S SIGNATURE <u>Carol Hurley</u>		24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Rd.</u>		ADDRESS <u>6</u>	

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06298  
6398 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Cockeysville</u>				OR TOWN <u>Cockeysville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ivy Hill Road</u>				STREET ADDRESS (If rural give location)		<u>Ivy Hill Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Nancy Brown Dashiell</u>				<u>7 27 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>4-15-1869</u>	<u>86</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>		<u>none</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>James T. Daniel</u>				<u>Louise Rowe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>none</u>		<u>Margessie A. Brumwell, Cockeysville</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary insufficiency</u>							<u>2 weeks.</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardio-vascular disease</u>							<u>years.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)			21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Sept. 1951</u> to <u>July 18, 1955</u> , that I last saw the deceased alive on <u>July 26, 1955</u> , and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Clayton B. Sherrill</u>				ADDRESS <u>M. D. Cockeysville, Md.</u>		DATE SIGNED <u>7/28/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-29-55</u>		<u>Wood Ridge</u>		<u>Pikesville, Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7/28/55</u>		<u>Wm. J. Chilcoat</u>		<u>Beob's Funeral Service Sparks, Md.</u>			

1000 1000

ALL

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06299

## CERTIFICATE OF DEATH

Reg. Dist. No.

Items 7, 13 Film 184 8-3-55 at

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>52 TOWN Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hosp.</u>		STREET ADDRESS (If rural give location) <u>263 Linden Ave.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Annie Belle Day</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>July 24 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH <u>5-5-</u>
9. AGE last birthday IF UNDER 1 YEAR, IF UNDER 24 HRS <u>76</u> yrs. Months Days Hours Min.		10. BIRTHPLACE (State or foreign country): <u>Md.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
13. FATHER'S NAME <u>Owen M. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Laura Mason</u>	
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>Laura Allen - same</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>			
ANTECEDENT CAUSE (B) <u>Generalized arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes mellitus</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-18</u> , 19 <u>55</u> , to <u>7-24</u> , 19 <u>55</u> that I last saw the deceased alive on <u>7-24</u> , 19 <u>55</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
SIGNATURE <u>William J. Sam, Jr.</u>		ADDRESS <u>565 S.H.</u>	
DATE SIGNED <u>7-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 27, 55</u>	
NAME OF CEMETERY OF CREMATORY <u>London Ok</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS <u>Frank St. Smith 814 W 36th St</u>	
REGISTRAR'S SIGNATURE			





Item 184 Film G184 8-5-55

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

6310

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Balto.</u> MARYLAND CITY (If outside corporate limits, write RURAL) <u>Catonsville</u> OR (If nearest town) TOWN <u>Catonsville</u>		STATE <u>Md.</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>1917 Guilford Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>SAMUEL R. DEAN</u> 5. SEX: <u>male</u> 6. COLOR OR RACE: <u>white</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u> 8. DATE OF BIRTH: <u>July 26, 1881</u>		DEATH: <u>July 28, 1955</u> 9. AGE (last birthday), IF UNDER 1 YEAR: <u>74</u> yrs Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painting Contractor (self Emp)</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
10B. KIND OF BUSINESS OR INDUSTRY:		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>John Dean</u>		14. MOTHER'S MAIDEN NAME: <u>Mina Dulin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.: <u>212-07-7675</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Raymond Wiedefeld-241 Rogers Forge Rd.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>931.7</u> ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		<u>Prostration, Heat</u> <u>2 1/2 days</u> <u>Leptospirosis</u> <u>1 1/2 days</u> either paralytic ilius with seepage, or rupture of hollow viscous from vomiting	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>Sarcinosis, Prostate</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office, bldg., etc)	
		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work Not while at work	
		21F. HOW DID INJURY OCCUR? Vomiting attendant upon the heat prostration	
22. I hereby certify that I attended the deceased from <u>7-27, 1955</u> , to <u>7-27, 1955</u> , that I last saw the deceased alive on <u>7-27, 1955</u> , and that death occurred at <u>10:39 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>7-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/1/55</u>	
DATE PEC'D BY LOCAL REGISTRAR		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u> LOCATION (City, town, or county) <u>Balto., Md.</u>	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS <u>[Signature]</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

By Phone: Ridgeway Nursing Home, admitted 1/30/55. 8-5-55 ams.

06301

MARYLAND

STATE DEPARTMENT OF HEALTH

6311

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Towson</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>427 Murdock Road</b>		STREET ADDRESS (If rural, give location) <b>427 Murdock Road</b>	
3. NAME OF DECEASED (First) <b>Miss Bertha</b> (Middle) (Last) <b>De Witt</b>		4. DATE OF DEATH (Month) <b>July</b> (Day) <b>18th</b> (Year) <b>1955</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH <b>Jan. 6, 1880</b>
9. AGE last birthday <b>75</b> yrs.		10. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mr. Charles Edgar De Witt</b>		14. MOTHER'S MAIDEN NAME <b>Ella Huston</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <b>215-09-7504 A</b>	
17. INFORMANT AND ADDRESS <b>Mr. John Anderson 612 Sussex Road #4</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
153X Immediate cause (a) <b>Intestinal Obstruction</b>			
Antecedent cause(s) (b) <b>Pos. Annular Ca. of Sigmoid</b>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Rt Hemiplegia - Arteriosclerotic</b>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 10, 1955</b> , to <b>July 18, 1955</b> , that I last saw the deceased alive on <b>July 18, 1955</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Lawrence C. Cook M.D.</b>		ADDRESS <b>6805 York Rd</b> DATE SIGNED <b>7/20/55</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE <b>July 21, 1955</b> NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b> LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)	
DATE REC'D BY LOCAL REG. <b>7/21/55</b>		REGISTRAR'S SIGNATURE <b>W. W. Hedrick</b> 24. FUNERAL DIRECTOR <b>Leonard J. Ruck</b> ADDRESS <b>5305 Harford Road #14</b>	

MARGIN RESERVED FOR BINDING

Dr. Post  
6805 York Road  
VA 3 2171

2-4

MARYLAND

STATE DEPARTMENT OF HEALTH

6312

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Reisterstown</b> LENGTH OF STAY <b>92 yrs</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Reisterstown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>69 Main Street</b>		STREET ADDRESS (If rural, give location) <b>69 Main Street</b>	
3. NAME OF DECEASED (Type or Print) <b>Blanche H Dickson</b>		4. DATE OF DEATH <b>July 6, 1955</b>	
6. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>June 26, 1863</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework for self</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <b>92</b> yrs.
11. FATHER'S NAME <b>Dr. Isaac N. Dickson</b>		11. BIRTHPLACE (State or foreign country) <b>Reisterstown, Md.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <b>No</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
16. SOCIAL SECURITY No. <b>None</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Sears</b>	
		17. INFORMANT AND ADDRESS <b>Dr. Isaac C. Dickson, Baltimore, Md.</b>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
153X Immediate cause (a) <b>Generalized Carcinomatosis</b>				<b>5 mo.</b>	
Antecedent cause(s) (b) <b>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</b>		(c) <b>Carcinoma of head of Cervix</b>		<b>1 yr ?</b>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <b>Feb 1955</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Cervix metastatic</b>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE <b>None</b> HOMICIDE <b>None</b>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>None</b> INJURY <b>None</b>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>None</b>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> <b>None</b>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **2-21**, 19**42**, to **July 6**, 19**55**, that I last saw the deceased alive on **July 5**, 19**55**, and that death occurred at **6** **A.M.**, from the causes and on the date stated above.

SIGNATURE **D.D. Ely** (Degree or title) **M.D.** ADDRESS **Reisterstown, Md.** DATE SIGNED **7-7-55**

23. BURIAL, CREMATION REMOVAL (Specify) **Burial** DATE **July 8, 1955** NAME OF CEMETERY OR CREMATORY **Luthern Cemetery** LOCATION (City, town, or county) (State) **Reisterstown, Md.**

DATE REC'D BY LOCAL REG. **7-12-55** REGISTRAR'S SIGNATURE **Mary Cline** 24. FUNERAL DIRECTOR **J.F. Eline & Sons, Reisterstown, Md.** ADDRESS

MARGIN RESERVED FOR BINDING

1955

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06314

MARYLAND

STATE DEPARTMENT OF HEALTH

6313

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>MD</b> COUNTY <b>BALTO.</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>CATONSVILLE</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>3 AUGUST AVE</b>		STREET ADDRESS (If rural, give location) <b>3 AUGUST AVE</b>	
3. NAME OF DECEASED (Type or Print) <b>CHARLES</b> (First) <b>W.</b> (Middle) <b>DIETERICH</b> (Last)		4. DATE OF DEATH <b>July</b> (Month) <b>8</b> (Day) <b>1955</b> (Year)	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MAR. 29, 1900</b>
9. AGE last birthday <b>55</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>R.B.X. REPAIRMAN</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JOHN F. DIETERICH</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET KUNERT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <b>212-05-0663</b>	
17. INFORMANT AND ADDRESS <b>MRS HILDA DIETERICH, 3 AUGUST AVE</b>			

15. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>6 mon</b>	
Immediate cause (a) <b>180X Hypernephroma R Kidney</b>					
Antecedent cause(s) (b).... <b>Metastasis to Lung &amp; Brain</b>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)....					
19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **2-4**, 19**55**, to **7-8**, 19**55**, that I last saw the deceased alive on **7-8**, 19**55**, and that death occurred at **5:15** p.m., from the causes and on the date stated above.

SIGNATURE <b>James E. Howard</b>		ADDRESS <b>Catonville</b>		DATE SIGNED <b>7-8</b>	
23. BURIAL, CREMATION (Specify) <b>BURIAL</b>		DATE <b>Jul. 11 / 55</b>		NAME OF CEMETERY OR CREMATORY <b>IMMANUEL CEMETERY</b>	
LOCATION (City, town, or county) <b>BALTO., MD.</b>					
DATE REC'D BY LOCAL REG. <b>7/9/55</b>		REGISTRAR'S SIGNATURE <b>D.E. Harry</b>		24. FUNERAL DIRECTOR <b>Harry H. Witte</b>	
				ADDRESS <b>4101 EDMONDSON AVE.</b>	

MARGIN RESERVED FOR BINDING

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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1980

Country	1950	1955	1960	1965	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025
Japan	7.0	7.5	8.0	8.5	9.0	9.5	10.0	10.5	11.0	11.5	12.0	12.5	13.0	13.5	14.0	14.5
Germany	10.0	10.5	11.0	11.5	12.0	12.5	13.0	13.5	14.0	14.5	15.0	15.5	16.0	16.5	17.0	17.5
France	11.0	11.5	12.0	12.5	13.0	13.5	14.0	14.5	15.0	15.5	16.0	16.5	17.0	17.5	18.0	18.5
Italy	12.0	12.5	13.0	13.5	14.0	14.5	15.0	15.5	16.0	16.5	17.0	17.5	18.0	18.5	19.0	19.5
Spain	13.0	13.5	14.0	14.5	15.0	15.5	16.0	16.5	17.0	17.5	18.0	18.5	19.0	19.5	20.0	20.5
Sweden	14.0	14.5	15.0	15.5	16.0	16.5	17.0	17.5	18.0	18.5	19.0	19.5	20.0	20.5	21.0	21.5
Belgium	15.0	15.5	16.0	16.5	17.0	17.5	18.0	18.5	19.0	19.5	20.0	20.5	21.0	21.5	22.0	22.5
United Kingdom	16.0	16.5	17.0	17.5	18.0	18.5	19.0	19.5	20.0	20.5	21.0	21.5	22.0	22.5	23.0	23.5
United States	17.0	17.5	18.0	18.5	19.0	19.5	20.0	20.5	21.0	21.5	22.0	22.5	23.0	23.5	24.0	24.5
Canada	18.0	18.5	19.0	19.5	20.0	20.5	21.0	21.5	22.0	22.5	23.0	23.5	24.0	24.5	25.0	25.5
Australia	19.0	19.5	20.0	20.5	21.0	21.5	22.0	22.5	23.0	23.5	24.0	24.5	25.0	25.5	26.0	26.5
South Korea	20.0	20.5	21.0	21.5	22.0	22.5	23.0	23.5	24.0	24.5	25.0	25.5	26.0	26.5	27.0	27.5
China	21.0	21.5	22.0	22.5	23.0	23.5	24.0	24.5	25.0	25.5	26.0	26.5	27.0	27.5	28.0	28.5
India	22.0	22.5	23.0	23.5	24.0	24.5	25.0	25.5	26.0	26.5	27.0	27.5	28.0	28.5	29.0	29.5
Brazil	23.0	23.5	24.0	24.5	25.0	25.5	26.0	26.5	27.0	27.5	28.0	28.5	29.0	29.5	30.0	30.5
Argentina	24.0	24.5	25.0	25.5	26.0	26.5	27.0	27.5	28.0	28.5	29.0	29.5	30.0	30.5	31.0	31.5
South Africa	25.0	25.5	26.0	26.5	27.0	27.5	28.0	28.5	29.0	29.5	30.0	30.5	31.0	31.5	32.0	32.5
Indonesia	26.0	26.5	27.0	27.5	28.0	28.5	29.0	29.5	30.0	30.5	31.0	31.5	32.0	32.5	33.0	33.5
Nigeria	27.0	27.5	28.0	28.5	29.0	29.5	30.0	30.5	31.0	31.5	32.0	32.5	33.0	33.5	34.0	34.5
Kenya	28.0	28.5	29.0	29.5	30.0	30.5	31.0	31.5	32.0	32.5	33.0	33.5	34.0	34.5	35.0	35.5
Uganda	29.0	29.5	30.0	30.5	31.0	31.5	32.0	32.5	33.0	33.5	34.0	34.5	35.0	35.5	36.0	36.5
Zambia	30.0	30.5	31.0	31.5	32.0	32.5	33.0	33.5	34.0	34.5	35.0	35.5				

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1. *Chlorophyll a* (Chl *a*)

Circumstance	Percentage (%)
Self-defense	85
To protect others	75
To protect property	65
To protect the community	55
To protect the environment	45
To protect the government	35

• *Journal of the American Medical Association*, 2000; 283: 2539-2543

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99

Figure 1. The effect of the concentration of the *Agrobacterium* suspension on the transformation efficiency of *Agrobacterium* strains.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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MARYLAND

STATE DEPARTMENT OF HEALTH

6314

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

|   |                               |   |                                       |
|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>COUNTY <b>Baltimore</b> MARYLAND   |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <b>Maryland</b> COUNTY <b>Baltimore</b>  |                                       |
| CITY (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>  |                               | CITY (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>  |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>2704 Alden Road</b>  |                               | STREET ADDRESS (If rural, give location) <b>2704 Alden Road</b>   |                                       |
| 3. NAME OF DECEASED (First) <b>Mr. Dominick</b> (Middle) <b>Di Stefano</b> (Last) <b>Di Stefano</b>   |                               | 4. DATE OF DEATH (Month) <b>July</b> (Day) <b>17th</b> (Year) <b>1955</b>   |                                       |
| 5. SEX <b>male</b>  | 6. COLOR OR RACE <b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>  | 8. DATE OF BIRTH <b>July 10, 1908</b> |
| 9. AGE last birthday <b>47</b> yrs.   |                               | 9. AGE last birthday (If under 1 year) Months Days Hours Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoemaker</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |                                       |
| 11. BIRTHPLACE (State or foreign country) <b>Virginia</b>   |                               | 12. CITIZEN OF WHAT COUNTRY <b>USA</b>  |                                       |
| 13. FATHER'S NAME <b>Mr. Luigi Di Stefano</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Stephanie Farace</b>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)   |                               | 16. SOCIAL SECURITY No.   |                                       |
| 17. INFORMANT AND ADDRESS <b>Mrs. Sadie Di Stefano 2704 Alden Road</b>  |                               |   |                                       |
| 18. MEDICAL CERTIFICATION   |                               | INTERVAL BETWEEN ONSET AND DEATH  |                                       |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                               |   |                                       |
| Immediate cause (a) <b>Carcinoma of head of cancer with generalized metastases</b>  |                               | <b>7 months</b>   |                                       |
| Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....  |                               |   |                                       |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  |                               |   |                                       |
| 19a. DATE OF OPERATION  |                               | 19b. MAJOR FINDINGS OF OPERATION  |                                       |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>   |                               |   |                                       |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)   |                               | PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)  |                                       |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |                               | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>   |                                       |
| HOW DID INJURY OCCUR?   |                               |   |                                       |
| 22. I hereby certify that I attended the deceased from <b>May</b> , 19 <b>55</b> , to <b>July</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>June 24</b> , 19 <b>55</b> , and that death occurred at <b>5:00</b> p.m., from the causes and on the date stated above. |                               |   |                                       |
| SIGNATURE <b>Albert Hume</b>  |                               | ADDRESS <b>800 North 2d</b> DATE SIGNED <b>7-19-55</b>  |                                       |
| 23. BURIAL CRIMATION REMOVAL (Specify) <b>Burial</b>  |                               | DATE <b>7-22-1955</b> NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b> LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b> |                                       |
| DATE REC'D BY LOCAL REG.  |                               | 24. FUNERAL DIRECTOR <b>Leonard J. Ruck, 5305 Harford Road #14</b>  |                                       |

MARGIN RESERVED FOR BINDING

Dr. Grott  
Dr. Harris  
8100 Harford Road

6262

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH  |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |  |  |
| COUNTY <u>BALTO. CO.</u> MARYLAND  |  |  |  | STATE <u>MD.</u> COUNTY <u>BALTO. CO.</u>  |  |  |  |
| CITY (If outside corporate limits, write RURAL, OR and give nearest town)  |  |  |  | CITY (If outside corporate limits, write RURAL and give nearest town)            |  |  |  |
| TOWN <u>HALETHROPE</u>   |  |  |  | TOWN <u>HALETHROPE</u>   |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |  |  |  | STREET ADDRESS (If rural give location)  |  |  |  |
| <u>1705 CARROLL AVE</u>  |  |  |  | <u>1705 CARROLL AVE.</u>   |  |  |  |
| 3. NAME OF DECEASED. (First) (Middle) (Last)   |  |  |  | 4. DATE (Month) (Day) (Year)   |  |  |  |
| <u>HERTHA M. DOERING</u>   |  |  |  | <u>7/6/55</u> 19 <u>55</u>   |  |  |  |
| 5. SEX: <u>F</u>   |  | 6. COLOR OR RACE: <u>W</u>   |  | 7. SINGLE MARRIED. WIDOWED, DIVORCED: <u>Married</u>                             |  | 8. DATE OF BIRTH: <u>9/17/1895</u>         |  |
| 9. AGE last birthday: <u>59</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic at home</u>                                      |  | 11. BIRTHPLACE (State or foreign country): <u>Germany</u>                        |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |  |
| 13. FATHER'S NAME: <u>Frank Traumann</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME: <u>John Doering, same</u>                              |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT & ADDRESS:                   |  |
|  |  |  |  |  |  |  |  |
| 18. MEDICAL CERTIFICATION  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (A) <u>Carcinoma of Breast</u> 1949  |  |  |  |  |  |  |  |
| ANTECEDENT CAUSE (B) <u>General Carcinomatosis</u> 1955  |  |  |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Myocardial infarct</u> 3 wks  |  |  |  |  |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION: <u>Jan 1950</u>  |  | 19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of Left Breast</u>  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21C. WHERE DID (City or town) (County) (State)                                   |  | 21D. WHERE DID INJURY OCCUR?               |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>July 6</u> 19 <u>55</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>55</u> , and that death occurred at <u>9:25</u> M, from the causes and on the date stated above. |  |  |  |  |  |  |  |
| SIGNATURE <u>[Signature]</u>   |  |  |  | ADDRESS <u>6509 Ocean St</u>   |  | DATE SIGNED <u>7/7/55</u>                  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | DATE THEREOF   |  | NAME OF CEMETERY OR CREMATORY  |  | LOCATION (City, town, or county) (State)   |  |
| <u>Burial</u>  |  | <u>7/9/55</u>  |  | <u>Meadowridge</u>   |  | <u>Howard Co.</u>                          |  |
| DATE REC'D BY LOCAL REGISTRAR  |  | REGISTRAR'S SIGNATURE  |  | FUNERAL DIRECTOR   |  | ADDRESS                                    |  |
| <u>July 11, 55</u>   |  | <u>[Signature]</u>   |  | <u>[Signature]</u>   |  | <u>28 Catons</u>                           |  |

MARGIN RESERVED FOR BINDING



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. .... 50

6315

06307

|  |                                  |  |                                      |  |   |                              |  |
|--|----------------------------------|--|--------------------------------------|--|---|------------------------------|--|
| 1. PLACE OF DEATH-<br>COUNTY<br><b>Baltimore</b>   |                                  | MARYLAND   |                                      | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE<br><b>Maryland</b>                               |   | COUNTY<br><b>Baltimore</b>   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>52 TOWN Catonsville</b>                      |                                  | LENGTH OF STAY<br>(in this place)                                      |                                      | CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWN Catonsville</b> |   |                              |  |
| HOSPITAL OR<br>INSTITUTION OR<br>STREET ADDRESS<br><b>601 Orpington Road</b>   |                                  |  |                                      | STREET<br>ADDRESS<br><b>601 Orpington Road</b>   |   | (If rural, give location)    |  |
| 3. NAME OF<br>DECEASED<br>(Type or Print)<br><b>AINNA MARY DONALDSON</b>   |                                  | (First) (Middle) (Last)  |                                      | 4. DATE<br>OF<br>DEATH<br><b>July 16, 1955</b>   |   | (Month) (Day) (Year)         |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED,<br>(Specify)<br><b>Widow</b> | 8. DATE OF BIRTH<br><b>9-27-1871</b> | 9. AGE last birthday<br><b>83</b> yrs.   | If under 1 year<br>Months Days Hours Min. |                              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At Home</b>            |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                       |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>                                 |   | 12. CITIZEN OF WHAT COUNTRY? |  |
| 13. FATHER'S NAME<br><b>Henry Taylor</b>   |                                  |  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |   |                              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |                                  | 16. SOCIAL SECURITY No.<br><b>None</b>                                 |                                      | 17. INFORMANT AND ADDRESS<br><b>Beatrice Long, Catonsville, Md</b>                               |   |                              |  |

### 18. MEDICAL CERTIFICATION

|   |  |   |
|---|--|---|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><b>443X Immediate cause</b>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs</b> |
| (a) <b>Hypertensive CV Disease</b>  |  |   |
| (b) Antecedent cause(s)<br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last |  |   |
| (c)   |  |   |

|   |  |
|---|--|
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |
|---|--|

|  |  |  |
|--|--|--|
| 19a. DATE OF OPERATION                           | 19b. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT<br>SUICIDE<br>HOMICIDE<br>(Specify) | PLACE (Home, farm, factory, street, office bldg., etc.)<br>OF INJURY                                 | (CITY OR TOWN) (COUNTY) (STATE)  |
| TIME (Month) (Day) (Year) (Hour)<br>OF INJURY    | INJURY OCCURRED<br>While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/> | HOW DID INJURY OCCUR?  |

22. I hereby certify that I attended the deceased from **July 16, 1955** to **July 16, 1955**, that I last saw the deceased alive on **July 16, 1955**, and that death occurred at **8:00** m., from the causes and on the date stated above.

|   |  |
|---|--|
| SIGNATURE<br><b>[Signature]</b>                             | DATE SIGNED<br><b>7/18/55</b>                                |
| 23. BURIAL, CREMATION<br>REMOVAL (Specify)<br><b>Burial</b> | DATE THEREOF<br><b>7-19-55</b>                               |
| NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd</b>       | LOCATION (City, town, or county)<br><b>Ellicott City, Md</b> |
| DATE REC'D BY LOCAL<br>REG.<br><b>7/18/55</b>               | REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                  |
| 24. FUNERAL DIRECTOR<br><b>F.C. Higinbotham</b>             | ADDRESS<br><b>Ellicott City, Md</b>                          |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



BUCKINGHAM A. J.

117 5 024

1880-1881

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6316

## CERTIFICATE OF DEATH

Reg. Dist. No. 31 ...

06308

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH.  |  |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |  |  |
| COUNTY <u>Baltimore</u>   |  | MARYLAND  |  | STATE <u>MD</u>  |  | COUNTY <u>Baltimore</u>  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>  |  |   |  | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u> |  |  |  |
| OR TOWN <u>Rural - Baltimore</u>  |  |   |  | OR TOWN <u>Rural - Baltimore</u>   |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Windsor Mill Rd</u>  |  |   |  | STREET ADDRESS (If rural give location) <u>Windsor Mill Rd</u>                                 |  |  |  |
| 3. NAME OF DECEASED: (Type or Print)  |  |   |  | 4. DATE OF DEATH:  |  |  |  |
| (First) <u>Hugh</u> (Middle) <u>-</u> (Last) <u>Louds</u>   |  |   |  | (Month) <u>July</u> (Day) <u>11</u> (Year) <u>1955</u>   |  |  |  |
| 5. SEX: <u>M</u>  |  | 6. COLOR OR RACE: <u>W</u>  |  | 7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify) <u>married</u>                                |  | 8. DATE OF BIRTH: <u>12/7/86</u>                               |  |
| 9. AGE last birthday <u>68</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Stationary Fireman</u> |  | 11. BIRTHPLACE (State or foreign country): <u>Melgarvie, Scotland</u>                          |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                     |  |
| 13. FATHER'S NAME: <u>Louds</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME: <u>Barah Lee</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>   |  |   |  | 16. SOCIAL SECURITY NO: <u>-151-05-6697</u>  |  | 17. INFORMANT & ADDRESS: <u>James Zister - Son in law</u>      |  |
| 18. MEDICAL CERTIFICATION   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                               |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>  |  |   |  |  |  | <u>1 month</u>   |  |
| ANTECEDENT CAUSE (B) <u>Diabetes mellitus</u>   |  |   |  |  |  | <u>5 yrs</u>   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |  |   |  |  |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |   |  |  |  |  |  |
| 19A. DATE OF OPERATION:   |  |   |  | 19B. MAJOR FINDINGS OF OPERATION   |  |  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)  |  | 21C. WHERE DID (City or town) (County) (State)   |  | 21D. TIME (Month) (Day) (Year) (Hour) (M.)                     |  |
|   |  |   |  |  |  |  |  |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>Jan 27, 1951</u> , to <u>July 11, 1955</u> , that I last saw the deceased alive on <u>July 6, 1955</u> , and that death occurred at <u>11:05 AM</u> , from the causes and on the date stated above. |  |   |  |  |  |  |  |
| SIGNATURE <u>Edwin G. Purpitt</u>   |  |   |  | ADDRESS <u>8204 Delbert Rd</u> DATE SIGNED <u>7/11/55</u>                                      |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | DATE THEREOF <u>7/14/55</u>   |  | NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>   |  | LOCATION (City, town, or county) (State) <u>P. Thonon N.Y.</u> |  |
| DATE REC'D BY LOCAL REGISTRAR <u>7-11-55</u>  |  | REGISTRAR'S SIGNATURE   |  | WILLIAM J. TICKNER & SONS* BALTO. 17, MD.  |  |  |  |





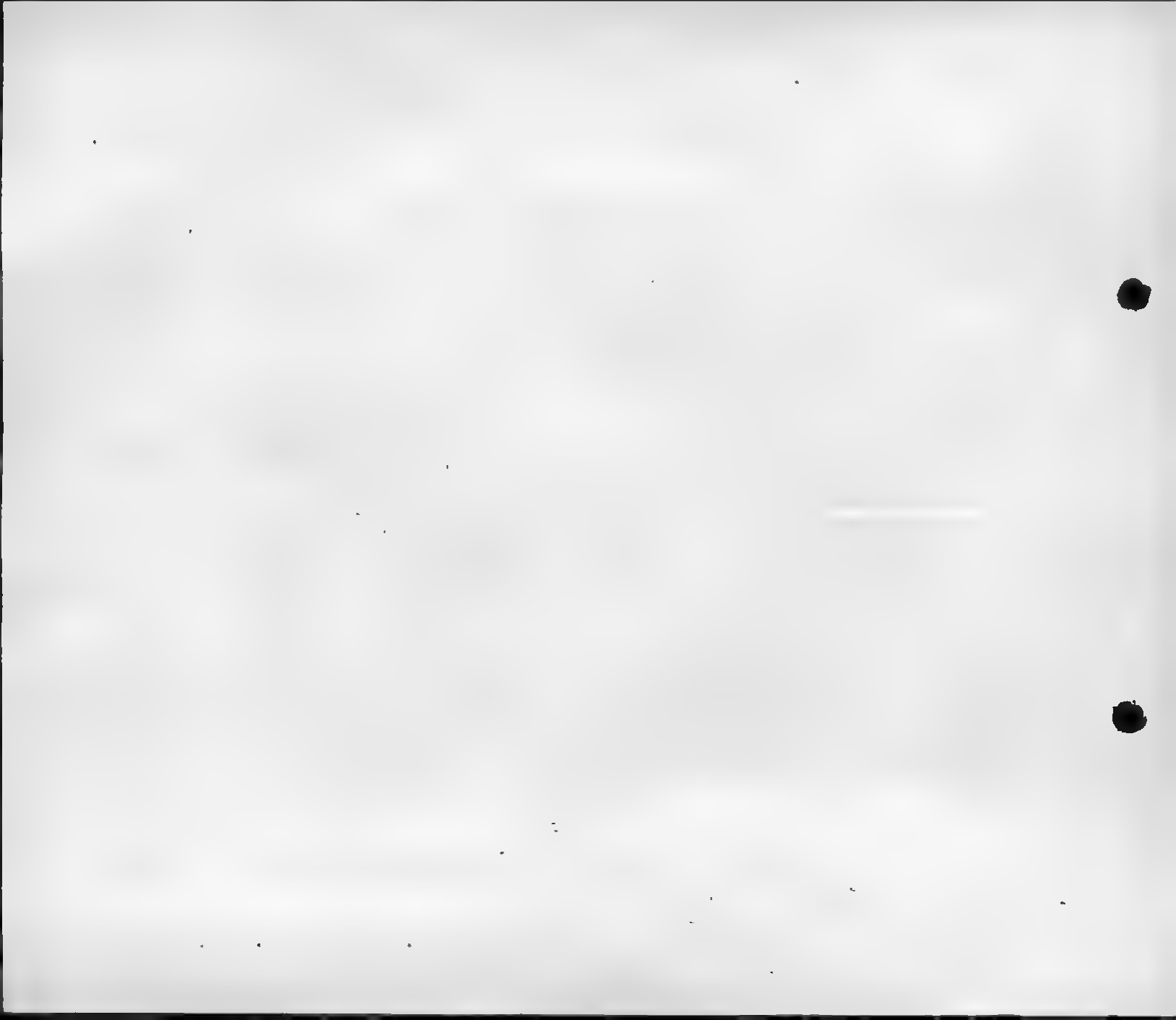
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06309  
6317 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                |  |                                       |
|--|--------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH  |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                                       |
| COUNTY <u>Baltimore</u>  | MARYLAND                       | STATE <u>Md.</u>   | COUNTY <u>Balto.</u>                  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town)  |                                       |
| TOWN <u>Catonsville</u>  |                                | TOWN <u>Catonsville</u>  |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                                | STREET ADDRESS (If rural give location)  |                                       |
| <u>39 Bloomsbury Ave.</u>  |                                | <u>39 Bloomsbury Ave.</u>  |                                       |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |                                | 4. DATE (Month) (Day) (Year)   |                                       |
| <u>LEON J. DOUGLASS</u>  |                                | DEATH: <u>July 2, 1955</u>   |                                       |
| 5. SEX: <u>Male</u>  | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>   | 8. DATE OF BIRTH: <u>May 27, 1893</u> |
| 9. AGE last birthday: <u>62</u> yrs  |                                | 10. BIRTHPLACE (State or foreign country): <u>Penna.</u>   |                                       |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>salesman</u>  |                                | 12. CITIZEN OF WHAT COUNTRY? <u>self employed</u>  |                                       |
| 13. FATHER'S NAME: <u>unknown</u>  |                                | 14. MOTHER'S MAIDEN NAME: <u>Katherine Buckingham</u>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service): <u>no</u>  |                                | 16. SOCIAL SECURITY NO. <u>17. INFORMANT &amp; ADDRESS</u>   |                                       |
| 18. MEDICAL CERTIFICATION  |                                | INTERVAL BETWEEN ONSET AND DEATH   |                                       |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                |  |                                       |
| IMMEDIATE CAUSE <u>420.1</u>   |                                |  |                                       |
| ANTECEDENT CAUSE (S)   |                                |  |                                       |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |                                |  |                                       |
| (A) <u>Cardiac Stenosis</u>  |                                |  |                                       |
| (B) <u>Recurrent Coronary Occlusion</u>  |                                | <u>2 mos</u>   |                                       |
| (C)  |                                |  |                                       |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                                |  |                                       |
| 19A. DATE OF OPERATION:  |                                | 19B. MAJOR FINDINGS OF OPERATION   |                                       |
|  |                                |  |                                       |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                |  |                                       |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc)   |                                       |
|  |                                | 21C. WHERE DID (City or town) (County) (State)   |                                       |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                       |
|  |                                | 21F. HOW DID INJURY OCCUR?   |                                       |
| 22. I hereby certify that I attended the deceased from <u>7/1/55</u> , to <u>7/28/55</u> that I last saw the deceased alive on <u>7/27</u> , 1955, and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above. |                                |  |                                       |
| SIGNATURE <u>Victor F. Waring</u>  |                                | DATE SIGNED <u>7/28/55</u>   |                                       |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |                                | DATE THEREOF <u>8/1/55</u>   |                                       |
| NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>  |                                | LOCATION (City, town, or county) (State) <u>Balto., Md.</u>  |                                       |
| DATE REC'D BY LOCAL REGISTRAR <u>8-1-55</u>  |                                | REGISTRAR'S SIGNATURE <u>Wm. J. Dickerson &amp; Sons</u>   |                                       |
|  |                                | 24. FUNERAL DIRECTOR ADDRESS <u>Balto., Md.</u>  |                                       |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6318

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                |   |
| COUNTY <u>Baltimore</u>  | MARYLAND  | STATE <u>Maryland</u>   | COUNTY <u>Anne Arundel</u>                            |
| CITY (If outside corporate limits, write RURAL and give nearest town)                                | LENGTH OF STAY (in this place)                  | CITY (If outside corporate limits, write RURAL and give nearest town) |   |
| X TOWN <u>Mt. Wilson</u>   | <u>10 days</u>                                  | TOWN <u>Rural</u>   | <u>02X 3</u>  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |   | STREET ADDRESS (If rural give location)                               |   |
| <u>02 Mt. Wilson State Hosp</u>  |   | <u>Gambrells, Maryland</u>  |   |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |   | 4. DATE (Month) (Day) (Year)  |   |
| (Type or Print) <u>Richard Edward DOVE Sr.</u>   |   | DATE OF DEATH <u>July 8, 1955</u>                                     |   |
| 5. SEX: 6. COLOR OR RACE   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH  | 9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. |
| <u>male</u> <u>white</u>   | <u>married</u>                                  | <u>July 23, 1893</u>  | <u>61</u> yrs. Months Days Hours Min.                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):         |   | 10B. KIND OF BUSINESS OR INDUSTRY                                     |   |
| <u>Farmer Tobacco</u>  |   | <u>Cumberland Md</u>  |   |
| 11. BIRTHPLACE (State or foreign country):   |   | 12. CITIZEN OF WHAT COUNTRY?  |   |
| <u>U.S.A.</u>  |   | <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME:   |   | 14. MOTHER'S MAIDEN NAME:   |   |
| <u>Sam Dove</u>  |   | <u>Cora Walker</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) |   | 16. SOCIAL SECURITY NO.   |   |
| <u>No</u>  |   | <u>none</u>   |   |
| 17. INFORMANT & ADDRESS:   |   |   |   |
| <u>ER Hodge Mt Wilson Md</u>   |   |   |   |

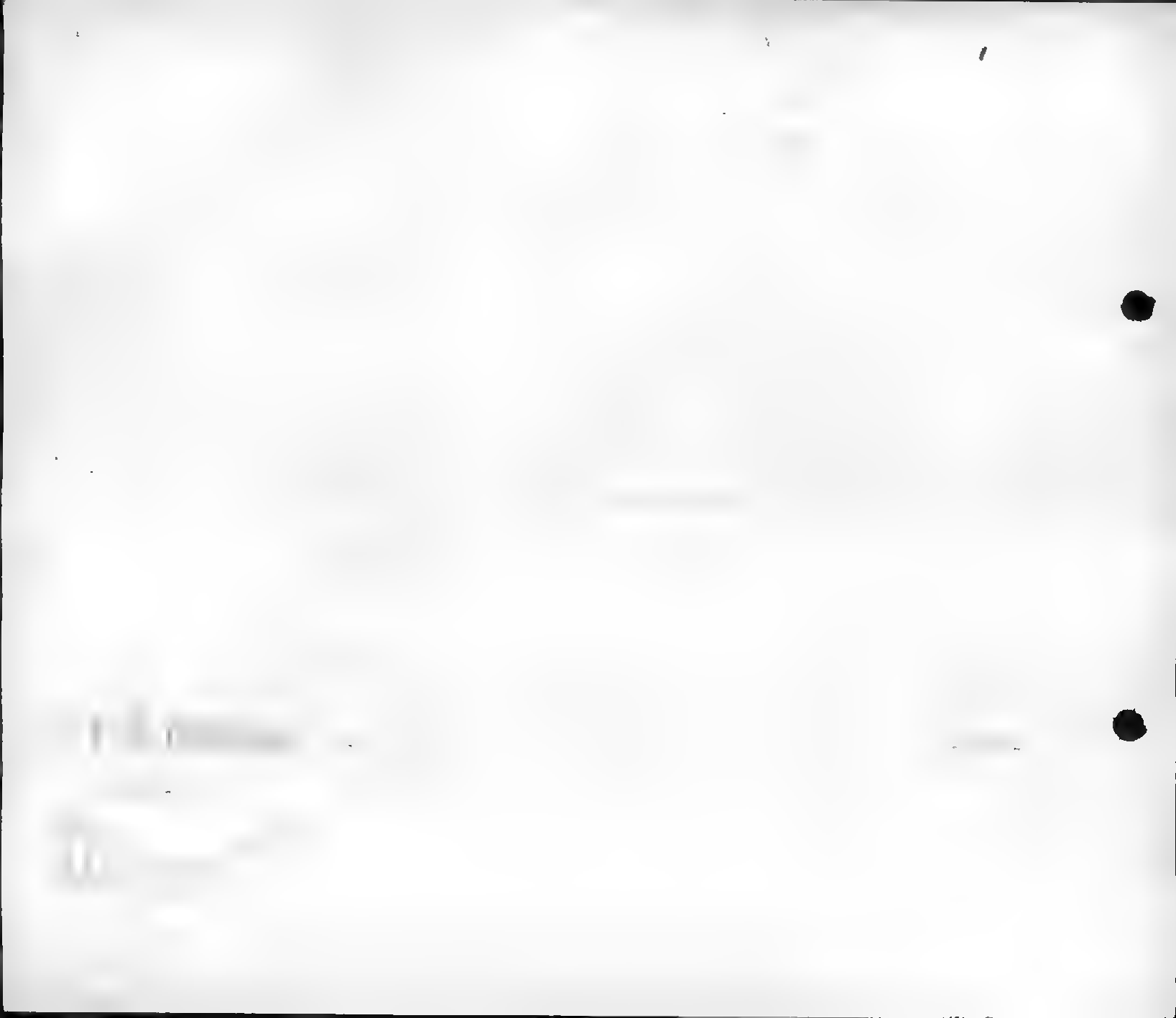
|  |                            |                                  |
|--|----------------------------|----------------------------------|
| 15. MEDICAL CERTIFICATION  |                            | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                            |                                  |
| IMMEDIATE CAUSE (A)  | <u>Cerebral Hemorrhage</u> | <u>3 days</u>                    |
| ANTECEDENT CAUSE (B)   | <u>arterio sclerosis</u>   | <u>10 years</u>                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST                         |                            |                                  |
| (C)  |                            |                                  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. |                            |                                  |

|  |  |  |
|--|--|--|
| 19A. DATE OF OPERATION:  | 19B. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   | 21C. WHERE DID (City or town) (County) (State)                                   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |

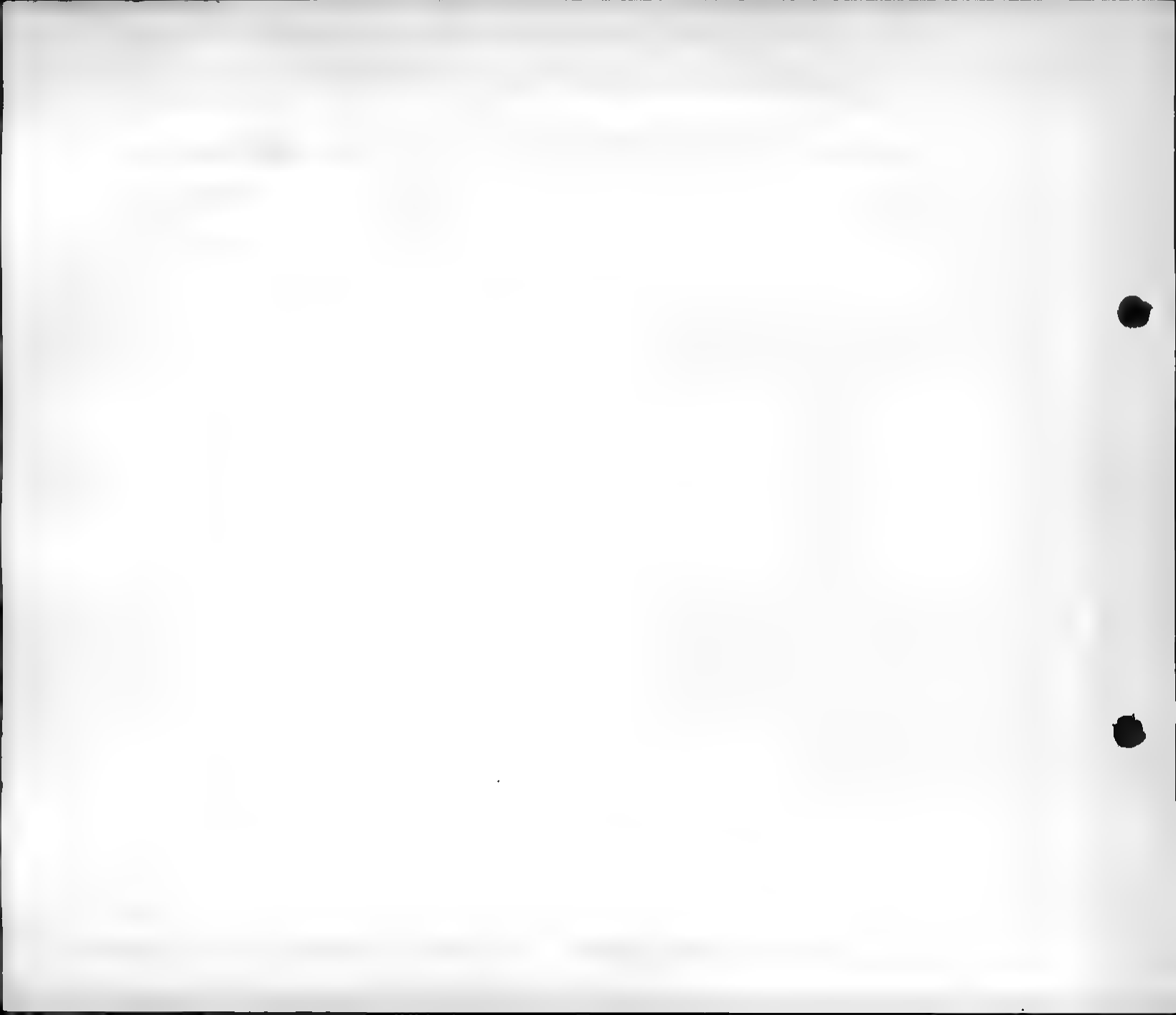
|  |  |   |  |
|--|--|---|--|
| 22. I hereby certify that I attended the deceased from <u>June 28, 1955</u> to <u>July 8, 1955</u> that I last saw the deceased alive on <u>July 5, 1955</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. |  |   |  |
| SIGNATURE <u>William H. H. H. H.</u>   |  | DATE SIGNED <u>July 8, 1955</u>                 |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | NAME OF CEMETERY OR CREMATORY                   |  |
| <u>burial</u>  |  | <u>Mt. Zion</u>                                 |  |
| DATE REC'D BY LOCAL REGISTRAR  |  | 24. FUNERAL DIRECTOR                            |  |
| <u>July 11, 1955</u>   |  | <u>Shirley Taylor &amp; Sons Annapolis, Md.</u> |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







6320

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

|   |                                |  |                                   |
|---|--------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH   |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                                   |
| COUNTY <u>Baltimore</u>   | MARYLAND                       | STATE <u>Md</u>  | COUNTY <u>Baltimore</u>           |
| CITY (If outside corporate limits, write RURAL and give nearest town)   |                                | CITY (If outside corporate limits, write RURAL and give nearest town)  |                                   |
| TOWN <u>Middle River, Balto.</u>  |                                | TOWN <u>Middle River Balto.</u>  |                                   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Linn Court</u>  |                                | STREET ADDRESS (If rural give location) <u>10 Linn Court</u>   |                                   |
| 3. NAME OF DECEASED (Type or Print)   |                                | 4. DATE (Month) (Day) (Year)   |                                   |
| (First) (Middle) (Last) <u>George Washington Emsor</u>  |                                | OF DEATH <u>7 - 10 19 55</u>   |                                   |
| 5. SEX: <u>male</u>   | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>  | 8. DATE OF BIRTH: <u>6-7-1869</u> |
| 9. AGE last birthday <u>86</u> yrs.   |                                | 10. IF UNDER 1 YEAR: Months Days Hours Min.  |                                   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>farmer on farm</u>   |                                | 12. BIRTHPLACE (State or foreign country): <u>Maryland</u>   |                                   |
| 13. FATHER'S NAME: <u>Shadrach Emsor</u>  |                                | 14. MOTHER'S MAIDEN NAME: <u>Rebecca Chilcoat</u>  |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>no</u>   |                                | 16. SOCIAL SECURITY NO. <u>719-12-5724</u>   |                                   |
| 17. IF Yes, give war or dates of service  |                                | 17. INFORMANT & ADDRESS: <u>wife - above address</u>   |                                   |
| 18. MEDICAL CERTIFICATION   |                                |  |                                   |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                |  | INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (A) <u>Pneumonia Edema -</u>  |                                |  | <u>24 hrs</u>                     |
| ANTECEDENT CAUSE (B) <u>Pneumonia - Cardiac Failure</u>   |                                |  | <u>1 week</u>                     |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Generalized Arteriosclerosis</u>  |                                |  | <u>—</u>                          |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                |  |                                   |
| 19A. DATE OF OPERATION: <u>7-5-55</u>   |                                | 19B. MAJOR FINDINGS OF OPERATION   |                                   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                |  |                                   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                | 21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)  |                                   |
| 21C. WHERE DID (City or town) (County) (State)  |                                | 21D. HOW DID INJURY OCCUR?   |                                   |
| 21E. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                | 21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                   |
| 22. I hereby certify that I attended the deceased from <u>July 5, 1955</u> , to <u>July 10, 1955</u> , that I last saw the deceased alive on <u>July 10, 1955</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above. |                                |  |                                   |
| SIGNATURE <u>Joseph J. Lammert</u>  |                                | ADDRESS <u>M D 30 Chambers Rd Beltsville - 7/11/55</u>   |                                   |
| DATE SIGNED <u>7-11-55</u>  |                                |  |                                   |
| 23. BURIAL, CREMATION, REMOVAL (Specify)  |                                | DATE THEREOF   |                                   |
| <u>Buried</u>   |                                | <u>7-13-55</u>   |                                   |
| NAME OF CEMETERY OR CREMATORY   |                                | LOCATION (City, town, or county) (State)   |                                   |
| <u>Black Rock</u>   |                                | <u>Butler, Balto. Md.</u>  |                                   |
| DATE REC'D BY LOCAL REGISTRAR <u>7-14-55</u>  |                                | REGISTRAR'S SIGNATURE <u>Glad Hurely</u>   |                                   |
| 24. FUNERAL DIRECTOR  |                                | ADDRESS  |                                   |
| <u>Brooks Funeral Service, Sparks, Md.</u>  |                                | <u>Sparks, Md.</u>   |                                   |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100-100000

100-100000

100-100000



6321

## CERTIFICATE OF DEATH

Reg. Dist. No. 3

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Catonsville LENGTH OF STAY (in this place) 65 days  
 TOWN Catonsville  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove St. Hosp. Catonsville, Md.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY 21-1-4  
 CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore #29  
 TOWN Baltimore  
 STREET ADDRESS (If rural give location) 4404 Mountview Rd. J

## 3. NAME OF DECEASED:

(First) Joseph (Middle) - (Last) Evans  
 (Type or Print)

## 4. DATE (Month) (Day) (Year) OF DEATH:

7 / 28 / 1955

## 5. SEX:

M.

## 6. COLOR OR RACE:

W.

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Mar.

## 8. DATE OF BIRTH:

7/15/75

## 9. AGE last birthday

80 yrs

## IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired):

Writer

## 10B. KIND OF BUSINESS OR INDUSTRY

Ship building

## 11. BIRTHPLACE (State or foreign country)

England

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

George Evans

## 14. MOTHER'S MAIDEN NAME:

unknown

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY No.

215-07-2397

## 17. INFORMANT &amp; ADDRESS:

Spit's Parents

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1  
 IMMEDIATE CAUSE

## ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

Ischemic

## (A) DUE TO

acute coronary occlusion

## (B) DUE TO

Arteriosclerosis

## (C) DUE TO

Senility

## INTERVAL BETWEEN ONSET AND DEATH

few minutes

several years

several years

unknown

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

Tuberculosis of Lungs

## 19A. DATE OF OPERATION:

A

## 19B. MAJOR FINDINGS OF OPERATION

Ischemic

## 20. AUTOPSY?

YES ☐ NO ☒

## 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

☐

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

Home

## 21C. WHERE DID (City or town) INJURY OCCUR?

Baltimore

## (County) (State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

7/28/55

## M.

## 21E. INJURY OCCURRED While at work Not while at work

☐ ☐

## 21F. HOW DID INJURY OCCUR?

Heart attack

22. I hereby certify that I attended the deceased from May 27, 1955, to July 28, 1955 that I last saw the deceased alive on July 28, 1955, and that death occurred at 5:25 PM, from the causes and on the date stated above.

SIGNATURE Dr. R. Radanski  
 M.D. Spring Grove St. Hosp. Catonsville

DATE SIGNED 7/28/55  
 ADDRESS Baltimore, Md.

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

## DATE THEREOF

8/1/55

## NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

## LOCATION (City, town, or county)

Balto., Md.

## (State)

## DATE REC'D BY LOCAL REGISTRAR

8-29-55

## REGISTRAR'S SIGNATURE

Dr. R. Radanski

## 24. FUNERAL DIRECTOR

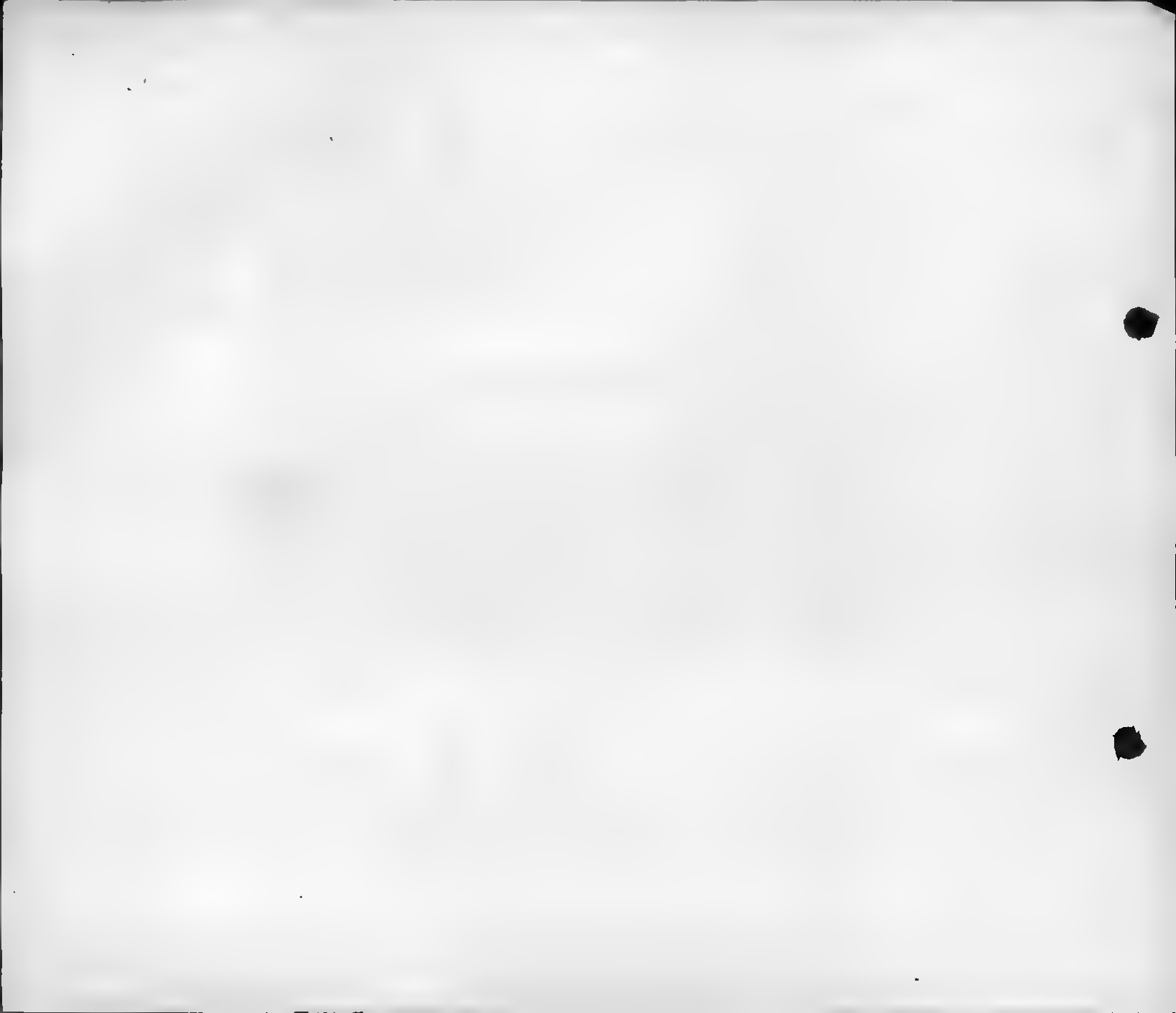
Wm. J. Vickrey & Sons

## ADDRESS

Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



06214

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

6251

Reg. Dist. No. 71

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH-<br>COUNTY <b>Baltimore</b> MARYLAND  |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <b>Maryland</b> COUNTY <b>Balto.</b>   |   |
| CITY (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>                        |                               | CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1401 Vesper Ave.</b>   |                               | STREET ADDRESS (If rural, give location) <b>6549 Parnell Ave.</b>                      |   |
| 3. NAME OF DECEASED<br>(Type or Print) <b>ALBERT WAINWRIGHT EVERHART</b>                                    |                               | 4. DATE OF DEATH<br>(Month) <b>July</b> (Day) <b>24</b> (Year) <b>1955</b>             |   |
| 5. SEX <b>male</b>  | 6. COLOR OR RACE <b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>                         | 8. DATE OF BIRTH <b>7/31/26</b>                           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mechanic</b> |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>steel</b>   | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> |
| 13. FATHER'S NAME <b>Victor Everhart</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>                                 |                               | 16. SOCIAL SECURITY NO. <b>219-129-811</b>   |   |
| 17. INFORMANT AND ADDRESS <b>Victor Everhart-1401 Vesper Ave. Baltimore, Md.</b>                            |                               |  |   |

|  |  |  |   |  |
|--|--|--|---|--|
| 18. MEDICAL CERTIFICATION  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>22 yrs.</b> |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |   |  |
| (a) <b>Immediate cause</b> <b>P. Perimetric Carditis</b>   |  |  |   |  |
| (b) <b>Antecedent cause(s)</b> <b>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</b>   |  |  |   |  |
| 11. OTHER SIGNIFICANT CONDITIONS <b>Conditions contributing to the death but not related to the disease or condition causing death.</b>  |  |  |   |  |
| 19a. DATE OF OPERATION <b>7/26/55</b> 19b. MAJOR FINDINGS OF OPERATION <b>Wound</b>  |  |  |   |  |
| 20. AUTOPSY? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input checked="" type="checkbox"/>   |  |  |   |  |
| 21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) <b>Home</b> (CITY OR TOWN) <b>Dundalk</b> (COUNTY) <b>Baltimore</b> (STATE) <b>Md.</b> |  |  |   |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <b>m.</b> INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR <b>fire</b>   |  |  |   |  |

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE **William M. Kelly** (Degree or title) **Physician** ADDRESS **Dundalk, Md.** DATE SIGNED **7/25/55**

21. BURIAL, CREMATION REMOVAL (Specify) **Burial** DATE THEREOF **7/26/55** NAME OF CEMETERY OR CREMATORY **St. Paul's** LOCATION (City, town, or county) **Baltimore, Md.** (State) **Md.**

DATE REC'D BY LOCAL REGISTAR'S SIGNATURE **July 25, 1955 William M. Kelly** ADDRESS **Walter Brooks Bradley, Inc. Dundalk, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED A. S.

1914

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6322  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

06315  
Reg. Dist.

|  |                                |  |                                      |
|--|--------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH:   |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                                      |
| COUNTY <i>Balto.</i>   | MARYLAND                       | STATE  | COUNTY <i>Balto.</i>                 |
| CITY (If outside corporate limits, write RURAL OR give nearest town)   | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town)                                   | TOWN                                 |
| X TOWN <i>Baltimore #6</i>   |                                | TOWN   | X                                    |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                                | STREET ADDRESS   |                                      |
| <i>Box 258 Jennings Lane</i>   |                                | <i>Same</i>  |                                      |
| 3. NAME OF DECEASED:   |                                | 4. DATE OF DEATH   |                                      |
| (First) (Middle) (Last)  |                                | Month (Day) (Year)   |                                      |
| <i>Louis Frederick Evering</i>   |                                | <i>July 22 1955</i>  |                                      |
| 5. SEX:  | 6. COLOR OF SKIN:              | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  | 8. DATE OF BIRTH:                    |
| <i>Male</i>  | <i>White</i>                   | <i>Married</i>   | <i>Apr. 21 1884</i>                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)   |                                | 10b. KIND OF BUSINESS OR INDUSTRY:   | 9. AGE Last birthday: <i>71</i> yrs. |
| <i>Retired</i>   |                                | <i>Farmer</i>  | Months Days Hours Min.               |
| 11. BIRTHPLACE (State or foreign country):   |                                | 12. CITIZEN OF WHAT COUNTRY?   |                                      |
| <i>Balto. Co. Md.</i>  |                                | <i>Ind.</i>  |                                      |
| 13. FATHER'S NAME:   |                                | 14. MOTHER'S MAIDEN NAME:  |                                      |
| <i>Christian F. Evering</i>  |                                | <i>Margaret A. Schuler</i>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |                                | 16. SOCIAL SECURITY No.:   |                                      |
|  |                                | <i>216-07-4900</i>   |                                      |
| 17. INFORMANT & ADDRESS:   |                                |  |                                      |
| <i>Christian F. Evering (Son).</i>   |                                |  |                                      |
| 18. MEDICAL CERTIFICATION  |                                |  |                                      |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |                                |  | INTERVAL BETWEEN ONSET AND DEATH     |
| 42.1 Immediate cause (a).....  |                                |  | <i>Immediate</i>                     |
| DUE TO <i>Coronary occlusion.</i>  |                                |  |                                      |
| Antecedent cause(s) (b).....   |                                |  |                                      |
| Diseases or conditions, if any, giving rise to the above cause DUE TO <i>Cardio Vascular disease</i>   |                                |  |                                      |
| stating underlying cause last (c)  |                                |  |                                      |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                |  |                                      |
| 19a. DATE OF OPERATION:  |                                | 19b. MAJOR FINDING OF OPERATION:   |                                      |
|  |                                |  |                                      |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                | 21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY)                                |                                      |
|  |                                |  |                                      |
| 21d. TIME (Month) (Day) (Year) (Hour) OF DEATH   |                                | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                      |
| <i>Death July 22 55 8A.M.</i>  |                                | <i>none</i>  |                                      |
| 21f. HOW DID INJURY OCCUR?   |                                |  |                                      |
| <i>none</i>  |                                |  |                                      |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                |  |                                      |
| SIGNATURE  |                                | DATE SIGNED  |                                      |
| <i>Dr. J. M. D.</i>  |                                | <i>Dr. J. M. D.</i>  |                                      |
| 23. BURIAL, CREMATION, REMOVAL (Specify):  |                                | DATE THEREOF   |                                      |
| <i>Burial</i>  |                                | <i>7-25-55</i>   |                                      |
| NAME OF CEMETERY OR CREMATORY  |                                | LOCATION (City, town, or county) (State)   |                                      |
| <i>Holy Redeemer</i>   |                                | <i>Balto Md.</i>   |                                      |
| DATE REC'D BY LOCAL REG.   |                                | 24. FUNERAL DIRECTOR ADDRESS   |                                      |
| <i>7-25-55</i>   |                                | <i>Alexander J. Ruok 5305 Hanford</i>  |                                      |



## MARYLAND STATE DEPARTMENT OF HEALTH

06316

2411 N. Charles Street, Baltimore

6323

## CERTIFICATE OF DEATH

Reg. Dist. No. 25

|  |                              |   |  |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH<br>COUNTY <b>BALTIMORE</b>   |                              | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <b>Maryland</b> COUNTY <b>MONTGOMERY</b>       |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>55 TOWSON</b>                        |                              | CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b> |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>13 Sheppard + Enoch Pratt Hosp</b>                               |                              | STREET ADDRESS<br><b>P.O. Box 306</b>   |  |
| 3. NAME OF DECEASED<br>(Type or Print) <b>STERLING DONALD EWALD</b>  |                              | 4. DATE OF DEATH<br>(Month) <b>July</b> (Day) <b>31</b> (Year) <b>1955</b>                    |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>                               | 8. DATE OF BIRTH<br><b>9 July 1900</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unemployed</b> |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   | 9. AGE last birthday<br><b>55 yrs.</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Kentucky</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  |
| 13. FATHER'S NAME<br><b>Louis P Ewald</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Goldan</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>                                      |                              | 16. SOCIAL SECURITY NO.<br><b>-</b>   |  |
| 17. INFORMANT AND ADDRESS<br><b>HOSPITAL RECORDS</b>   |                              |   |  |

## 18. MEDICAL CERTIFICATION

|  |  |   |
|--|--|---|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |
| (a) Immediate cause<br><b>Cerebral Hemorrhage</b>  |  |   |
| (b) Antecedent cause(s)<br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last<br><b>Unknown</b>  |  |   |
| (c) OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><b>Paranoid Schizophrenia with post-traumatic operative Syndrome (Lobotomy)</b> |  |   |

|  |  |   |                |   |
|--|--|---|----------------|---|
| 19a. DATE OF OPERATION                     |  | 19b. MAJOR FINDINGS OF OPERATION  |                | 20. AUTOPSY?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)    |  | PLACE (Home, farm, factory, street, OF office bldg., etc.)<br><b>INJURY</b>                       | (CITY OR TOWN) | (COUNTY) (STATE)  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |                | HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from Nov 17, 1946, to July 31, 1955, that I last saw the deceased alive on July 30, 1955, and that death occurred at 4 25 A.M., from the causes and on the date stated above.

SIGNATURE Harry M. Wurdack M.D. ADDRESS Washington, D.C. DATE SIGNED July 31, 1955

|   |                       |  |                                  |         |
|---|-----------------------|--|----------------------------------|---------|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF          | NAME OF CEMETERY OR CREMATORY                        | LOCATION (City, town, or county) | (State) |
| <b>Removal</b>                          | <b>July 31, 1955</b>  | <b>Marion F. Hyson</b>                               | <b>Washington, D.C.</b>          |         |
| DATE REC'D BY LOCAL REG.                | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS                         |                                  |         |
| <b>July 31, 1955</b>                    | <b>Mabel C. Gray</b>  | <b>Marion F. Hyson, Inc.</b><br><b>1300-N St. NW</b> |                                  |         |

MARGIN RESERVE FOR BINING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
AUG 1



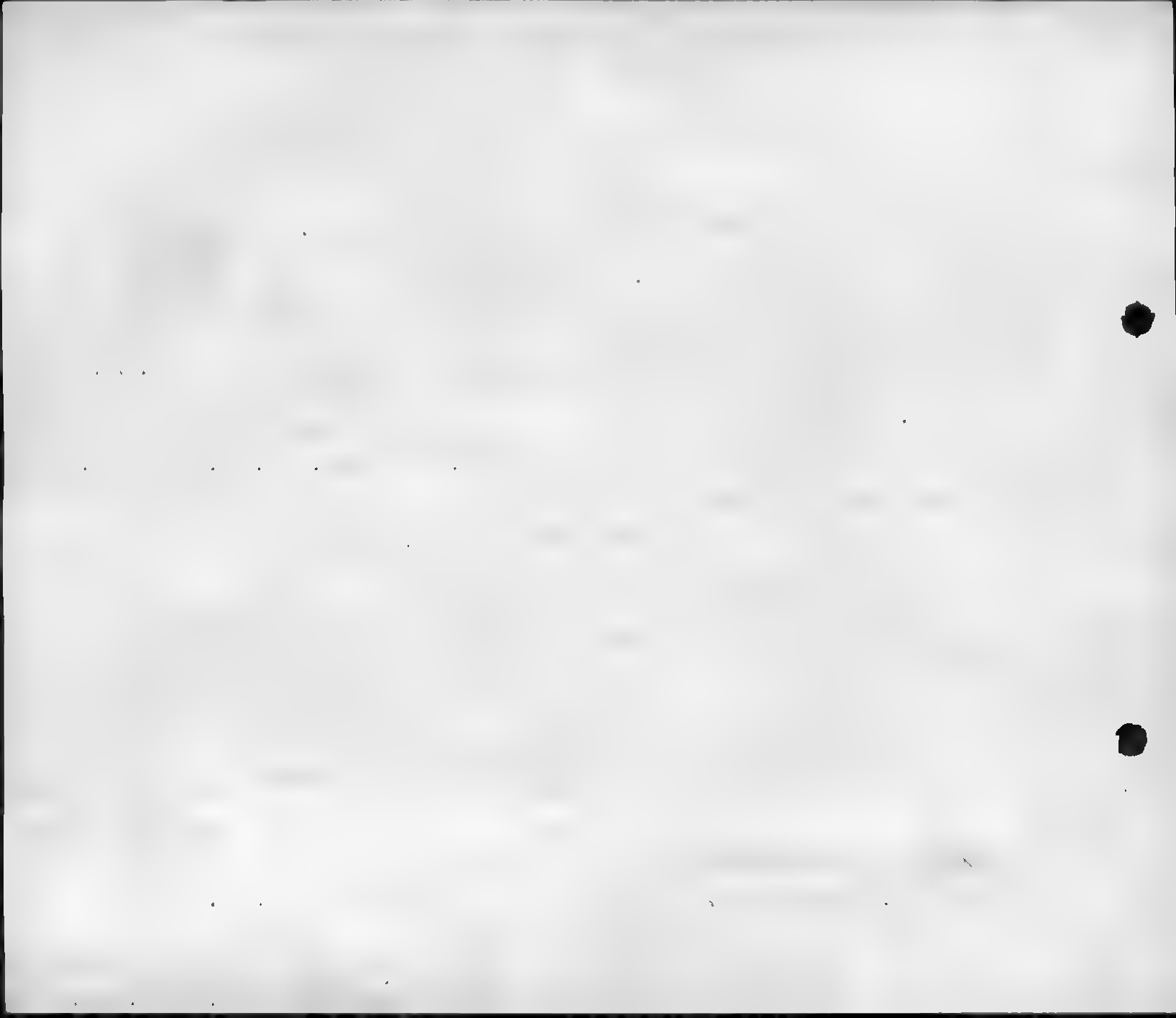
6324  
**CERTIFICATE OF DEATH**

Reg. Dist. No.

|  |  |  |                                  |
|--|--|--|----------------------------------|
| 1. PLACE OF DEATH  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                                  |
| COUNTY <b>BALTIMORE</b>  | MARYLAND                                     | STATE <b>MARYLAND</b>  | COUNTY                           |
| CITY (If outside corporate limits, write RURAL OR TOWN <b>FORT HOWARD</b> )  | LENGTH OF STAY (in this place) <b>7 DAYS</b> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>BALTIMORE</b>   | <b>3Y014</b>                     |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>  |  | STREET ADDRESS (If rural give location) <b>215 E. BELVEDERE AVENUE</b>   |                                  |
| 3. NAME OF DECEASED (Type or Print) <b>EDWARD J. FAIDLEY</b>   |  | 4. DATE (Month) (Day) (Year) OF DEATH: <b>JULY 16 1955</b>   |                                  |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b>                | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>  | 8. DATE OF BIRTH <b>11/24/06</b> |
| 9. AGE last birthday: IF UNDER 1 YEAR Months Days Hours Min. <b>48 yrs</b>   |  | 10. BIRTHPLACE (State or foreign country): <b>BALTIMORE, MARYLAND</b>  |                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life.) <b>OWNER OF SEAFOOD STALL</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY: <b>SEAFOOD</b>  |                                  |
| 11. FATHER'S NAME: <b>JOHN W. FAIDLEY</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                  |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>YES WW-II</b>   |  | 14. MOTHER'S MAIDEN NAME: <b>FLOSSIE DICKEY</b>  |                                  |
| 15. SOCIAL SECURITY NO. <b>213-03-6739</b>   |  | 17. INFORMANT & ADDRESS: <b>CLIN.REC.VET.ADM.HOSP., FT.HOWARD, MD.</b>   |                                  |
| 16. MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH   |                                  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |                                  |
| IMMEDIATE CAUSE <b>581.0</b>   |  |  |                                  |
| ANTECEDENT CAUSE (S)   |  |  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |  |  |                                  |
| (A) <b>CIRRHOSIS OF THE LIVER</b>  |  |  |                                  |
| (B)  |  |  |                                  |
| (C)  |  |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |                                  |
| 19A. DATE OF OPERATION: <b>2</b>   |  | 19B. MAJOR FINDINGS OF OPERATION   |                                  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |                                  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                                  |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?   |  |  |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>VA</b>  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                  |
| 21F. HOW DID INJURY OCCUR?   |  |  |                                  |
| 22. I hereby certify that I attended the deceased from <b>JULY 9, 1955</b> , to <b>JULY 16 1955</b> , and that death occurred at <b>3:20P</b> M. from the causes and on the date stated above. |  |  |                                  |
| SIGNATURE <b>WILLIAM B. VANDEGRIET, M.D.</b>   |  | ADDRESS <b>VAH, FORT HOWARD, MD.</b>   |                                  |
| DATE SIGNED <b>7/17/55</b>   |  |  |                                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>  |                                  |
| DATE REC'D BY LOCAL REGISTRAR <b>7/18/55</b>   |  | LOCATION (City, town, or county) <b>BALTIMORE, MARYLAND</b>  |                                  |
| REGISTRAR'S SIGNATURE <b>W. B. VanDegrift</b>  |  | 24. FUNERAL DIRECTOR <b>WILLIAM J. TICKNER &amp; SON INC.</b>  |                                  |
|  |  | ADDRESS <b>NORTH &amp; PENNSYLVANIA AVE. BALTO., MD.</b>   |                                  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



06318

## MARYLAND STATE DEPARTMENT OF HEALTH

6752

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 44

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH-<br>COUNTY <u>BALTO.</u> MARYLAND                                     |  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>W. VA.</u> COUNTY <u>KANAWHA</u>  |   |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u> |  | CITY (If outside corporate limits, write RURAL and give nearest town) <u>HANDLEY</u> |   |
| TOWN <u>DUNDALK 22</u>  |  | TOWN <u>HANDLEY</u>  |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2524 DURWOOD RD.</u>                       |  | STREET ADDRESS (If rural, give location) <u>(RURAL)</u>                              |   |
| 3. NAME OF DECEASED (Type or Print)   |  | 4. DATE OF DEATH   |   |
| (First) <u>CHARLES</u> (Middle) <u>JAMES</u> (Last) <u>FILBIN</u>                       |  | (Month) <u>JULY</u> (Day) <u>21</u> (Year) <u>1955</u>                               |   |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W.</u>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>MARRIED</u>                      | 8. DATE OF BIRTH <u>JAN. 31, 1901</u>                   |
| 9. AGE last birthday <u>54</u> yrs.   | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRAYMAN</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>                                    | 11. BIRTHPLACE (State or foreign country) <u>W. VA.</u> |
| 13. FATHER'S NAME <u>JOHN FILBIN</u>  |  | 14. MOTHER'S MAIDEN NAME <u>ADDIE REYNOLDS</u>                                       |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>             |  | 16. SOCIAL SECURITY No. <u>WM. R. LIPFORD</u>  |   |
| 17. INFORMANT <u>WM. R. LIPFORD</u>   |  | 12. CITIZEN OF WHAT COUNTRY?   |   |

## 18. MEDICAL CERTIFICATION

|   |  |  |
|---|--|--|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4-5 yrs.</u>                              |
| (a) <u>Immediate cause</u> <u>Coronary Occlusion</u>  |  |  |
| (b) <u>Antecedent cause(s)</u> <u>Hypertension &amp; V.D.</u>   |  |  |
| (c) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>                         |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |
| 19a. DATE OF OPERATION <u>7-25-55</u>   | 19b. MAJOR FINDINGS OF OPERATION <u>7-25-55</u>  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                    | PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY <u>Home</u>                                | (CITY OR TOWN) (COUNTY) (STATE)  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | HOW DID INJURY OCCUR?  |

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100-100000

20

6325

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

COUNTY **Baltimore County** MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 TOWN  
 HOSPITAL OR 15 years  
 INSTITUTION OR Sheppard & Enoch Pratt Hospital  
 STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Washington**  
 CITY (If outside corporate limits, write RURAL, and give nearest town)  
 OR  
 TOWN **Hagerstown**  
 STREET ADDRESS (If rural give location)  
**117 S. Potomac Street**

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

**Jela****Hoffman****Firey**

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

**7****5****19****55**

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

**Female****white****widow****11/6/72****82**

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

**housewife****Washington County, Maryland****U.S.A.**

## 13. FATHER'S NAME:

**Joseph T. Hoffman**

## 14. MOTHER'S MARRIED NAME:

**Mary McCaully**

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

**no**

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

**Hospital Records**

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**422.1  
Immediate cause**

(a) DUE TO

**Broncho pneumonia**Antecedent causes (s)  
Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.

(b) DUE TO

**Chronic myocarditis**

(c) DUE TO

**Generalized arteriosclerosis**

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

**Manic depressive Psychosis: Depressed 15 yr +**

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

Interval Between Onset And Death

**Term.  
10 yr +**

## 20. AUTOPSY?

Yes ☒ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY m.INJURY OCCURRED  
While at Not While  
Work ☐ At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Aug 30, 1940** to **July 5, 1955**, that I last saw the deceased alive on **July 5, 1955**, and that death occurred at **9:30 PM.**, from the causes and on the date stated above.  
 SIGNATURE (Degree or title) ADDRESS DATE SIGNED  
**M. Elgin, M.D.** **THE SHEPPARD & ENOCH PRATT HOSPITAL** **Towson, MD. 7/6/55**

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATION

## ASSOCIATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

**7-537****AW. Hedrick****NORMENT FUNERAL HOME****308 S. POTOMAC ST.  
HAGERSTOWN, MD.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>COUNTY <u>Balto.</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Md</u> COUNTY <u>Balto</u>   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Paspeburg</u>                        |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Paspeburg</u>                        |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>495-Fitch Ave</u>   |                                  | STREET ADDRESS (If rural, give location)<br><u>495-Fitch Ave</u>   |  |
| 3. NAME OF DECEASED<br>(First) <u>John</u> (Middle) <u>R.</u> (Last) <u>Foard</u>                                     |                                  | 4. DATE OF DEATH<br>(Month) <u>July</u> (Day) <u>27</u> (Year) <u>1953</u>   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>  | 8. DATE OF BIRTH<br><u>Nov. 8-1904</u> |
| 9. AGE last birthday<br><u>50</u> yrs.  |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Electrical Mechanic</u> |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Balto. Co. Md</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>Frank B. Foard</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Hattie Smith</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> |                                  | 16. SOCIAL SECURITY NO.<br><u>212-01-0814</u>  |  |
| 17. INFORMANT AND ADDRESS<br><u>Mrs. John R. Foard</u>  |                                  |  |  |

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1  
Immediate cause

(a) myocardial infarction.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary thrombosis

(c)

INTERVAL BETWEEN ONSET AND DEATH

Sudden death

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

Paroxysmal auricular tachycardia

2 years.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION                        |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 21. ACCIDENT (Specify)<br>SUICIDE<br>HOMICIDE |  | PLACE (Home, farm, factory, street, OF office bldg., etc.)<br>INJURY                                 |  | (CITY OR TOWN) (COUNTY) (STATE)   |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY    |  | INJURY OCCURRED<br>While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from Dec 28, 1945, to May 28, 1955, that I last saw the deceased

alive on May 28, 1955, and that death occurred at 7:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Harvey L. Fuller

MD

Rd 1 Rd

Baltimore

6 July 28/55

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 23. BURIAL, CREMATION REMOVAL (Specify)<br><u>Burial</u> |  | DATE THEREOF<br><u>7/30/55</u>                       |  | NAME OF CEMETERY OR CREMATORY<br><u>Parthwood</u>   |  | LOCATION (City, town, or county) (State)<br><u>Balto. City Md</u> |  |
| DATE REC'D BY LOCAL REG.<br><u>July 28/55</u>            |  | REGISTRAR'S SIGNATURE<br><u>Mr. M. D. Reifneider</u> |  | 24. FUNERAL DIRECTOR<br><u>Lassahn Funeral Home</u> |  | ADDRESS<br><u>1401 Belair Rd.</u>                                 |  |

BUREAU V. S.

AUG 2



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06321  
6327 CERTIFICATE OF DEATH

Reg. Dist. No. 45

|   |                                |   |  |
|---|--------------------------------|---|--|
| 1. PLACE OF DEATH:  |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |  |
| COUNTY <u>Balto</u>   | MARYLAND                       | STATE <u>md</u>   | COUNTY <u>1-17</u>                                 |
| CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Middleborough</u>  | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <u>Middleborough</u> |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>345 St George Road</u>   |                                | STREET ADDRESS (If rural give location)   |  |
| 3. NAME OF DECEASED:  |                                | 4. DATE OF DEATH:   |  |
| (First) <u>Mary</u>   | (Middle) <u>A</u>              | (Last) <u>Stacy</u>   | (Month) <u>7</u> (Day) <u>1</u> (Year) <u>1955</u> |
| 5. SEX: <u>F</u>  | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>                                      | 8. DATE OF BIRTH: <u>Aug 13 1882</u>               |
| 9. AGE last birthday: <u>72</u> yrs.  |                                | 10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS  |  |
| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>at home</u>   |                                | 10b. KIND OF BUSINESS OR INDUSTRY:  |  |
| 11. BIRTHPLACE (State or foreign country): <u>md</u>  |                                | 12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>  |  |
| 13. FATHER'S NAME: <u>James Strobel</u>   |                                | 14. MOTHER'S MAIDEN NAME: <u>Elizabeth Bailey</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |                                | 16. SOCIAL SECURITY No.:  |  |
| 17. INFORMANT & ADDRESS: <u>Mrs. Mabel Hill 345 St George Road</u>  |                                |   |  |
| 18. MEDICAL CERTIFICATION   |                                |   |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                | Interval Between Onset And Death  |  |
| 443X Immediate cause (a) <u>Cerebral hemorrhage</u>   |                                | 20  |  |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>hypertensive cardiovascular dis.</u>  |                                | Several yrs.  |  |
| (c) <u>Generalized arteriosclerosis</u>   |                                | Several yrs.  |  |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  |                                |   |  |
| 19a. DATE OF OPERATION:   |                                | 19b. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY?  |                                | Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)   |                                | PLACE (Home, farm, factory, street, office bldg., etc.)   |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |
| HOW DID INJURY OCCUR?   |                                |   |  |
| 22. I hereby certify that I attended the deceased from June 19 53, to July 30 19 55, that I last saw the deceased alive on 6/20 19 55, and that death occurred at 11:30 PM, from the causes and on the date stated above. |                                |   |  |
| SIGNATURE <u>J. Hill</u>  |                                | DATE SIGNED <u>7/1/55</u>   |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)  |                                | DATE THEREOF  |  |
| Burial  |                                | July 4/55   |  |
| NAME OF CEMETERY OR CREMATORY   |                                | LOCATION (City, town, or county) (State)  |  |
| New Cathedral Cem   |                                | Baltimore   |  |
| DATE REC'D BY LOCAL REGISTRAR   |                                | FUNERAL DIRECTOR  |  |
| July 5, 1955  |                                | Ullrich Funeral Home 4210 Baltimore   |  |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

EXHIBIT V. S.

6328

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH:

COUNTY BALTO MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town)  
 TOWN BOWLEYS QUARTERS  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 310A GOOSE HARBOR RD

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY BALTO  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN BOWLEYS QUARTERS  
 STREET ADDRESS (If rural, give location)  
Box 310 A GOOSE HARBOR RD.

3. NAME OF DECEASED: (First) (Middle) (Last)  
IRWIN D FOSTER  
 (Type or Print)

4. DATE OF DEATH: (Month) (Day) (Year)  
7/26 1955

5. SEX: M 6. COLOR OR RACE: W 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH:

9. AGE last birthday: 6/24/1882 73 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: WELDER

11. BIRTHPLACE (State or foreign country):

PENN.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

DUDLEY T FOSTER

14. MOTHER'S MAIDEN NAME:

MARTHA DAVID

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

181X  
 Immediate cause

(a)

DUE TO

Cerebro-Vascular accident

INTERVAL BETWEEN ONSET AND DEATH

2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

Carcinoma of Bladder2 yrs

(c)

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)  
 SUICIDE  
 HOMICIDE

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
 OF INJURY

INJURY OCCURRED  
 While at Not while  
 M. work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 24, 1955, to July 26, 1955, that I last saw the deceased alive on July 26, 1955, and that death occurred at 2 P., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):  
BURIAL

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

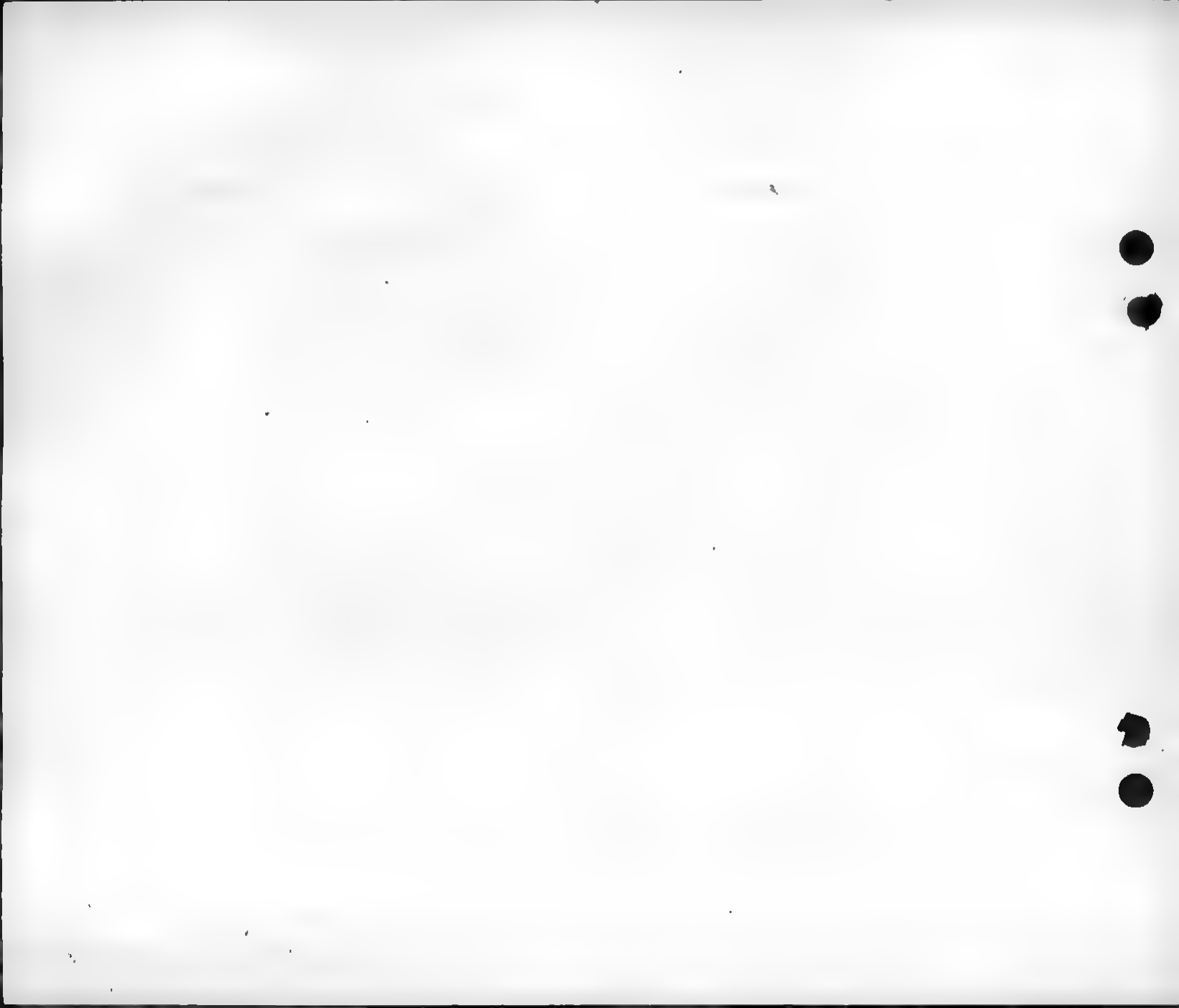
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6329  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06323  
Reg. Dist. No. 41

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH:<br>COUNTY <u>BALTIMORE</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Lodge Forest - 19</u><br>TOWN <u>Lodge Forest - 19</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Same -</u>  |  |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>Maryland</u> COUNTY <u>---</u><br>CITY (If outside corporate limits write RURAL and give nearest town) <u>Baltimore 22</u><br>TOWN <u>Baltimore 22</u><br>STREET ADDRESS (If rural, give location) <u>2211 Aiken Street</u> |  |  |  |
| 3. NAME OF DECEASED:<br>(Type or Print) <u>CHARLES</u><br>(First) <u>a</u> (Middle) <u>Fulda</u> (Last)  |  | 4. DATE OF DEATH <u>July 4</u> 19 <u>55</u><br>(Month) (Day) (Year)   |  | 5. SEX: <u>M</u> 6. COLOR OR RACE: <u>W</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u> 8. DATE OF BIRTH: <u>pt. 26, 1881</u> 9. AGE Last birthday: <u>66</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.                                     |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, if retired): <u>Owner Transfer Co</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY: <u>MD</u>  |  | 11. BIRTHPLACE (State or foreign country): <u>MD</u>   |  |  |  |
| 13. FATHER'S NAME: <u>Frank W. Fulda</u>   |  | 14. MOTHER'S MAIDEN NAME: <u>Mary F. Dulaney</u>  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): <u>(If Yes, give war or dates of service)</u>   |  | 16. SOCIAL SECURITY No: <u>---</u>  |  | 17. INFORMANT & ADDRESS: <u>Mrs. R. Fulda 2211 Aiken St</u>  |  |  |  |
| 18. MEDICAL CERTIFICATION  |  |   |  |  |  |  |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.<br><u>X50X</u><br>Immediate cause (a) ... <u>ROWNING</u> DUE TO<br>Antecedent cause(s) (b) ...<br>Diseases or conditions, if any, giving rise to the above cause DUE TO<br>stating underlying cause last (c)  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>---</u>   |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic by arteriosclerosis</u>   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION: <u>---</u>   |  | 19b. MAJOR FINDING OF OPERATION: <u>---</u>   |  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Lodge Forest - 19</u>   |  | 21c. (City or town, County, State) <u>Baltimore 22 MD</u>  |  |  |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-4-55 5:30 PM</u>  |  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |  | 21f. HOW DID INJURY OCCUR? <u>While preparing box for insurance</u>  |  |  |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |  |  |  |  |  |
| SIGNATURE <u>[Signature]</u>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/6/55</u><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>M. D. ASSISTANT MEDICAL EXAM <input type="checkbox"/> |  |  |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>  |  | DATE THEREOF <u>July 7, 1955</u>  |  | NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>   |  |  |  |
| DATE REC'D BY LOCAL REG. <u>7/6/55</u>   |  | REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  | 24. FUNERAL DIRECTOR <u>Edmondson Ave</u>  |  |  |  |
| ADDRESS <u>---</u>   |  | ADDRESS <u>1701-03 N. Patterson Park Ave</u>  |  |  |  |  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

6330

06324

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. PLACE OF DEATH-<br>COUNTY Baltimore  |  | MARYLAND   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE Maryland COUNTY                            |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN Villa Nova                        |  | LENGTH OF STAY<br>(In this place)<br>8 yrs                       |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN Baltimore |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br>Katherine Robb Nursing Home<br>4105 Essex Road.                    |  | STREET ADDRESS<br>(If rural, give location)<br>2901 St. Paul St. |  |  |  |
| 3. NAME OF DECEASED<br>(Type or Print)  |  | (First)  |  | (Last)   |  |
| GERTRUDE  |  | LILLIAN  |  | GARRATT  |  |
| 5. SEX<br>female  |  | 6. COLOR OR RACE<br>white  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single                                    |  |
| 8. DATE OF BIRTH<br>Dec. 30, 1885   |  | 9. AGE last birthday<br>69 yrs                                   |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br>July 22, 1955                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired)<br>housewife        |  | 10b. KIND OF BUSINESS OR INDUSTRY - - -                          |  | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland                           |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 13. FATHER'S NAME<br>David Garratt                               |  | 14. MOTHER'S MAIDEN NAME<br>Mary Phillips  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)<br>no |  | 16. SOCIAL SECURITY No.  |  | 17. INFORMANT AND ADDRESS<br>Mr. David R. Garrett<br>3519 Yolando Road                     |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  | 18. MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 443 Immediate cause   |  | (a) Cerebro-vascular thrombosis   |  | 8 days   |  |
| Antecedent cause(s)   |  | (b) Generalized arteriosclerosis  |  | 15 years   |  |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last                                    |  | (c) Degenerative cardiovascular disease   |  | 20 years   |  |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  | Diabetes Mellitus   |  | 25 years   |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)   |  | PLACE (Home, farm, factory, street, or office bldg., etc.)  |  | (CITY OR TOWN) (COUNTY) (STATE)  |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?  |  |

22. I hereby certify that I attended the deceased from Sept., 1946 to July, 1955, that I last saw the deceased alive on July 22, 1955, and that death occurred at 2:25 P.m., from the causes and on the date stated above.

SIGNATURE DATE SIGNED

|  |  |                       |  |                               |  |                                  |  |         |  |
|--|--|-----------------------|--|-------------------------------|--|----------------------------------|--|---------|--|
| 23. BURIAL CREMATION REMOVAL (Specify) |  | DATE                  |  | NAME OF CEMETERY OR CREMATORY |  | LOCATION (City, town, or county) |  | (State) |  |
| Burial                                 |  | July 23, 1955         |  | Mt. Carmel Cemetery           |  | Baltimore                        |  |         |  |
| DATE REC'D BY LOCAL REG.               |  | REGISTRAR'S SIGNATURE |  | 24. FUNERAL DIRECTOR          |  | ADDRESS                          |  |         |  |
| 27-53                                  |  | H. H. H. H. H.        |  | HENRY SANDER & SONS, INC.     |  | Baltimore Md.                    |  |         |  |

MARGIN RESERVE FOR BINING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06325

6331

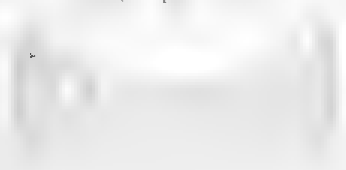
## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                            |  |                                       |  |                          |  |  |
|--|----------------------------|--|---------------------------------------|--|--------------------------|--|--|
| 1. PLACE OF DEATH:   |                            |  |                                       | 2. USUAL RESIDENCE (HOME) OF DECEASED.   |                          |  |  |
| COUNTY <b>BALTO.</b> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town) <b>140 yw.</b><br>TOWN <b>CATONSVILLE</b><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spring Grove State Hospital</b>   |                            |  |                                       | STATE <b>MD.</b> COUNTY <b>BALTO.</b><br>CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>BALTIMORE CITY</b><br>STREET ADDRESS (If rural give location)<br>Last address- <b>2122 No. Fulton Ave.</b> |                          |  |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><b>George B. GEES.</b>   |                            |  |                                       | 4. DATE (Month) (Day) (Year) OF DEATH: <b>7 - 2 - 55</b> 19  |                          |  |  |
| 5. SEX: <b>M</b>   | 6. COLOR OR RACE: <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):  | 8. DATE OF BIRTH: <b>May 16, 1890</b> | 9. AGE last birthday: <b>65</b> yrs  | 10. UNDER 1 YEAR: Months | 11. UNDER 24 HRS.: Days Hours Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>PLUMBER</b>  |                            | 10B. KIND OF BUSINESS OR INDUSTRY:   |                                       | 11. BIRTHPLACE (State or foreign country): <b>MARYLAND</b>   |                          | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME: <b>Richard H. Gees</b>  |                            |  |                                       | 14. MOTHER'S MAIDEN NAME: <b>Charlotte Mansfield</b>   |                          |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE? (Yes, no, or unk.): <b>NONE</b>   |                            | 16. SOCIAL SECURITY NO.: <b>NONE</b>   |                                       | 17. INFORMANT & ADDRESS: <b>RUTH GEES - 512 Castle Rd, Balto.</b>  |                          |  |  |
| 18. MEDICAL CERTIFICATION  |                            |  |                                       |  |                          | 19. INTERVAL BETWEEN ONSET AND DEATH   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                            |  |                                       |  |                          |  |  |
| IMMEDIATE CAUSE <b>451X</b>  |                            |  |                                       |  |                          |  |  |
| ANTECEDENT CAUSE (S):  |                            |  |                                       |  |                          |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST   |                            |  |                                       |  |                          |  |  |
| (A) <b>Arteriosclerotic aneurysm abdominal</b>   |                            |  |                                       |  |                          |  |  |
| (B) <b>Generalized arteriosclerosis</b>  |                            |  |                                       |  |                          |  |  |
| (C) <b>Generalized arteriosclerosis</b>  |                            |  |                                       |  |                          |  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                            |  |                                       |  |                          |  |  |
| 19A. DATE OF OPERATION: <b>6/20/55</b>   |                            | 19B. MAJOR FINDINGS OF OPERATION: <b>Large abdominal aneurysm left leg</b>   |                                       |  |                          | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                            | 21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)  |                                       | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |                          |  |  |
| 21D. TIME (Month) (Day) (Year) OF INJURY   |                            | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                       | 21F. HOW DID INJURY OCCUR?   |                          |  |  |
| 22. I hereby certify that I attended the deceased from <b>12-15-</b> , 19 <b>65</b> , to <b>7-2-</b> , 19 <b>55</b> that I last saw the deceased alive on <b>7-2-</b> , 19 <b>55</b> and that death occurred at <b>8:50 PM</b> , from the causes and on the date stated above. |                            |  |                                       |  |                          |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                            | DATE THEREOF   |                                       | NAME OF CEMETERY OR CREMATORY  |                          | LOCATION (City, town, or county) (State)   |  |
| <b>Burial</b>  |                            | <b>July 5, 1955</b>  |                                       | <b>Baltimore Cemetery</b>  |                          | <b>Baltimore, Md.</b>  |  |
| DATE REC'D BY LOCAL REGISTRAR  |                            | REGISTRAR'S SIGNATURE  |                                       | 24. FUNERAL DIRECTOR   |                          | ADDRESS  |  |
| <b>JUL 4 - 1955</b>  |                            | <b>Thomas J. Tichauer &amp; Son, Balto.</b>  |                                       | <b>2122 No. Fulton Ave.</b>  |                          | <b>Baltimore, Md.</b>  |  |



1000



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

6332

6326

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH-<br>COUNTY <u>Balto</u> MARYLAND   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>md</u> COUNTY <u>Balto</u>      |  |
| CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Balto 20</u>                           |  | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> |  |
| TOWN <u>Balto 20</u>   |  | TOWN <u>Balto</u>  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 704, E Side Blackhead Rd</u>                                      |  | STREET ADDRESS (If rural, give location) <u>614 Woodbine Ave Towson 4</u>          |  |
| 3. NAME OF DECEASED (First) <u>H</u> (Middle) <u>Grant</u> (Last) <u>German</u>                                    |  | 4. DATE OF DEATH (Month) <u>July</u> (Day) <u>16</u> (Year) <u>1955</u>            |  |
| 5. SEX <u>male</u>   |  | 6. COLOR OR RACE <u>White</u>  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>  |  | 8. DATE OF BIRTH <u>Dec 17-1870</u>  |  |
| 9. AGE last birthday <u>84 yrs.</u>  |  | 10. BIRTHPLACE (State or foreign country) <u>Balto Co md</u>                       |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>       |  | 12. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>                               |  |
| 13. FATHER'S NAME <u>Howell Price German</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Catherine P Stahl</u>                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO. <u>NONE</u>  |  |
| 17. INFORMANT AND ADDRESS <u>Mrs Grant German #704 E Side Balto 20</u>   |  | 18. MEDICAL CERTIFICATION  |  |

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

572X

Immediate cause

(a) Chronic Hepatitis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION no 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒

22. I hereby certify that I attended the deceased from June 1st, 1953, to July 17, 1955, that I last saw the deceased

alive on July 17, 1955, and that death occurred at 7:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG. 7/24/55

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial 7/20/55 Wauke Chapel Meth Balto md  
6212 Harley Lansdown Funeral Home 7401 Belair Rd

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

—

422 117 111

100

6333

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

|  |                           |  |                                      |   |                 |  |                 |
|--|---------------------------|--|--------------------------------------|---|-----------------|--|-----------------|
| 1. PLACE OF DEATH:   |                           |  |                                      | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |                 |  |                 |
| COUNTY <u>Baltimore</u>  |                           | MARYLAND   |                                      | STATE <u>Md.</u>  |                 | COUNTY <u>Balto</u>  |                 |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Towson</u>   |                           | LENGTH OF STAY (in this place) <u>74 yrs</u>   |                                      | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u> |                 |  |                 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>70 Bodda Nursing Home</u>   |                           |  |                                      | STREET ADDRESS (If rural give location) <u>35 Willow Ave</u>                                |                 |  |                 |
| 3. NAME OF DECEASED: (Type or Print) <u>William Morris German</u>  |                           |  |                                      | 4. DATE OF DEATH: (Month) (Day) (Year) <u>July 2 - 1955</u>                                 |                 |  |                 |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>  | 8. DATE OF BIRTH: <u>Oct 25-1880</u> | 9. AGE last birthday <u>74</u> yrs  | IF UNDER 1 YEAR | IF UNDER 24 HRS  | IF UNDER 24 HRS |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Labr</u>   |                           | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Lumber Hardware</u>  |                                      | 11. BIRTHPLACE (State or foreign country): <u>Towson Md.</u>                                |                 | 12. CITIZEN OF WHAT COUNTRY: <u>USA</u>                    |                 |
| 13. FATHER'S NAME: <u>Henry German</u>   |                           |  |                                      | 14. MOTHER'S MAIDEN NAME: <u>Francis Holland</u>  |                 |  |                 |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)   |                           | 16. SOCIAL SECURITY NO. <u>217-09-1149</u>   |                                      | 17. INFORMANT'S ADDRESS: <u>Wm German 628 Annandale Rd</u>                                  |                 |  |                 |
| 18. MEDICAL CERTIFICATION  |                           |  |                                      |   |                 | INTERVAL BETWEEN ONSET AND DEATH                           |                 |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                           |  |                                      |   |                 |  |                 |
| IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>  |                           |  |                                      |   |                 | 2 days   |                 |
| ANTECEDENT CAUSE (S) DUE TO (B) <u>Arterio-sclerosis</u>   |                           |  |                                      |   |                 | 5 years  |                 |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)  |                           |  |                                      |   |                 |  |                 |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                           |  |                                      |   |                 |  |                 |
| 19A. DATE OF OPERATION: <u>0</u>   |                           |  |                                      | 19B. MAJOR FINDINGS OF OPERATION  |                 |  |                 |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |  |                                      |   |                 |  |                 |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg, etc.)   |                                      | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                                |                 |  |                 |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                           | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                      | 21F. HOW DID INJURY OCCUR?  |                 |  |                 |
| 22. I hereby certify that I attended the deceased from <u>July, 1936</u> , to <u>2 July, 1955</u> , that I last saw the deceased alive on <u>2 July, 1955</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above. |                           |  |                                      |   |                 |  |                 |
| SIGNATURE <u>Charles H. Gere</u>   |                           |  |                                      | ADDRESS <u>6701 York Rd Balto Md</u>  |                 | DATE SIGNED <u>2 July 55</u>                               |                 |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                           | DATE THEREOF <u>July 5-1955</u>  |                                      | NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>  |                 | LOCATION (City, town, or county) (State) <u>Towson Md.</u> |                 |
| DATE REC'D BY LOCAL REGISTRAR <u>July 2, 1955</u>  |                           | REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>   |                                      | FUNERAL DIRECTOR <u>John Burns</u>  |                 | ADDRESS <u>1610 York Rd.</u>                               |                 |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE MA. OYSTERS

1955

1955

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06228

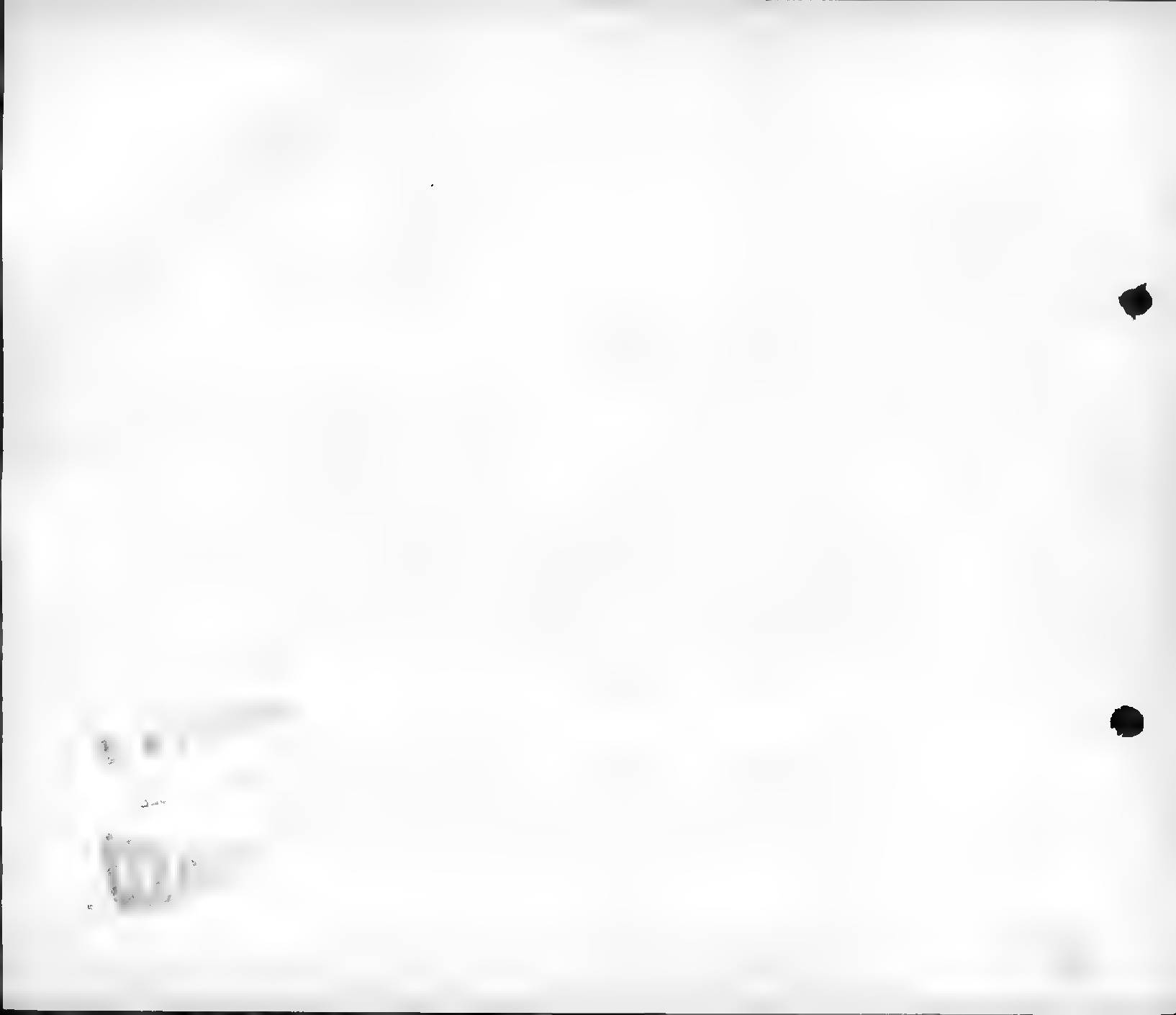
6263

## CERTIFICATE OF DEATH

Reg. Dist. No.

42

|  |                                |  |                                     |
|--|--------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH:   |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                                     |
| COUNTY <u>BALTIMORE</u>  | MARYLAND                       | STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>  |                                     |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>HALETHORPE</u>   | LENGTH OF STAY (In this place) | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>HALETHORPE</u>   |                                     |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>1208 FRANCIS AVE.</u>  |                                | STREET ADDRESS (If rural give location)<br><u>1208 FRANCIS AVE</u>   |                                     |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |                                | 4. DATE (Month) (Day) (Year) OF DEATH:   |                                     |
| <u>ANNA H. GITTINGS</u>  |                                | <u>JULY 2 1955</u>   |                                     |
| 5. SEX: <u>FEMALE</u>  | 6. COLOR OR RACE: <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>   | 8. DATE OF BIRTH: <u>AUG 6 1887</u> |
| 9. AGE last birthday: <u>67</u> yrs.   |                                | 10. AGE last birthday: IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.   |                                     |
| 11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>   |                                | 12. CITIZEN OF WHAT COUNTRY?   |                                     |
| 13. FATHER'S NAME: <u>JOHN MULLEN</u>  |                                | 14. MOTHER'S MAIDEN NAME: <u>LAURA CANNON</u>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMY OR FORCE? (Yes, no, or unk.) (If Yes, give war or dates of service)   |                                | 16. SOCIAL SECURITY NO. <u>NONE</u>  |                                     |
| 17. INFORMANT & ADDRESS: <u>LAMBERT R. GITTINGS 1208 FRANCIS AVE</u>   |                                |  |                                     |
| 18. MEDICAL CERTIFICATION  |                                | INTERVAL BETWEEN ONSET AND DEATH   |                                     |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                |  |                                     |
| 443X IMMEDIATE CAUSE (A) <u>apoplexy</u>   |                                | 3 hrs  |                                     |
| ANTECEDENT CAUSE (S) (B) <u>coronary atherosclerosis</u>   |                                | 2 yrs  |                                     |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>hypertension</u>  |                                | 5 yrs  |                                     |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>General arteriosclerosis</u>   |                                | 5 yrs  |                                     |
| 19A. DATE OF OPERATION:  |                                | 19B. MAJOR FINDINGS OF OPERATION   |                                     |
|  |                                |  |                                     |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.  |                                     |
| 21C. WHERE DID (City or town) (County) (State)   |                                | INJURY OCCUR?  |                                     |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                     |
| 21F. HOW DID INJURY OCCUR?   |                                |  |                                     |
| 22. I hereby certify that I attended the deceased from <u>July 1, 1955</u> , to <u>July 2, 1955</u> that I last saw the deceased alive on <u>July 2 1955</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. |                                |  |                                     |
| SIGNATURE <u>Dr. B. B. Brumback</u>  |                                | ADDRESS <u>1509 Main St. ELKridge 27 Md.</u>   |                                     |
| DATE SIGNED <u>7/2/55</u>  |                                |  |                                     |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>   |                                | DATE THEREOF <u>JULY 5, 1955</u>   |                                     |
| NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>  |                                | LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>  |                                     |
| DATE REC'D BY LOCAL REGISTRAR <u>July 4 55</u>   |                                | REGISTRAR'S SIGNATURE <u>Mr. Kieffer</u>   |                                     |
| 24. FUNERAL DIRECTOR   |                                | ADDRESS <u>Joseph J. Ambrose 1535 Sulphur Sp. - Del.</u>   |                                     |





06333

## MARYLAND STATE DEPARTMENT OF HEALTH

6333

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

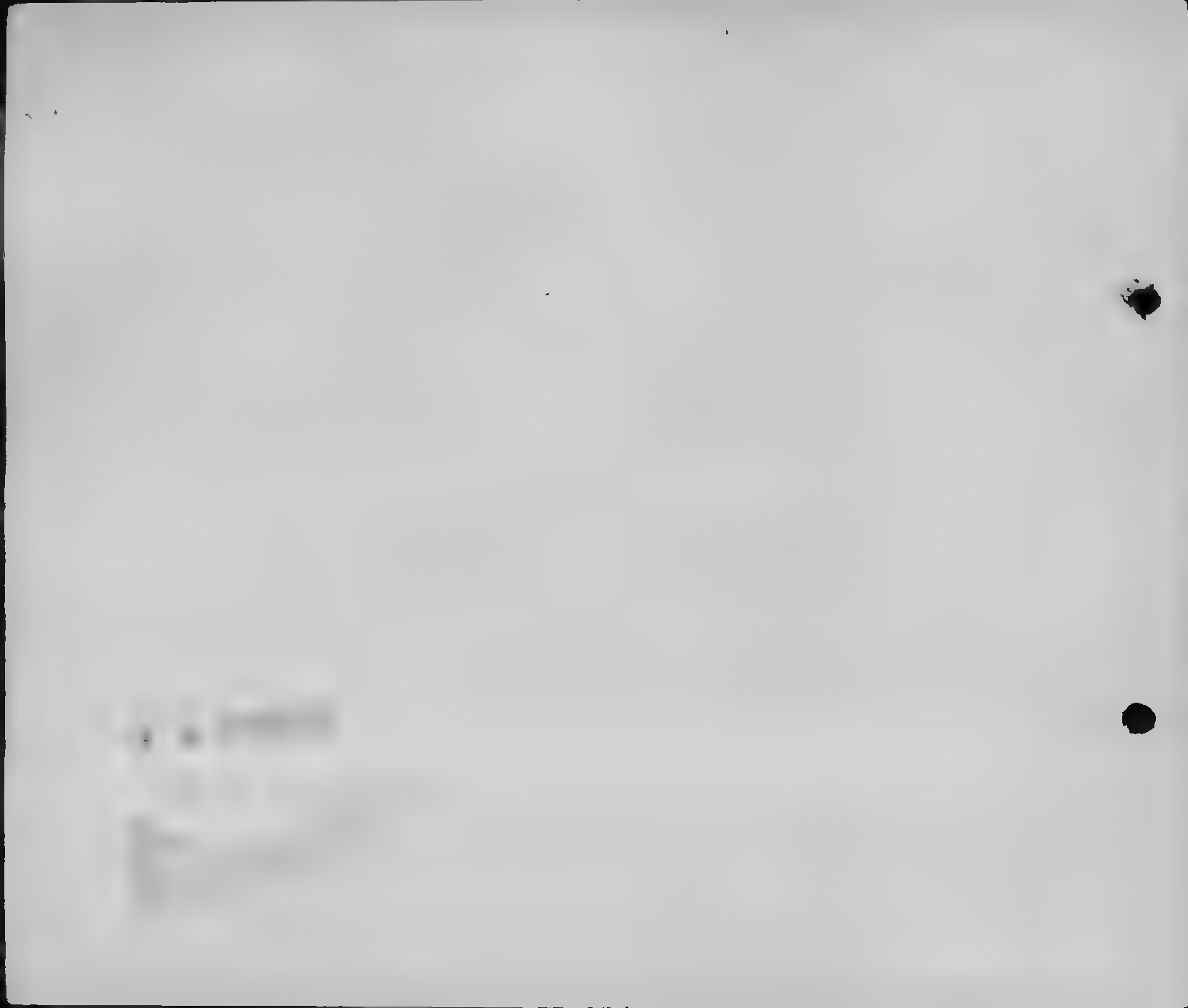
Reg. Dist. No. 32

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH:<br>COUNTY <b>Baltimore</b><br>CITY (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <b>Maryland</b> COUNTY <b>Baltimore</b><br>CITY (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b><br>STREET ADDRESS (If rural, give location) <b>715 Silver Creek Rd.</b> |   |
| 3. NAME OF DECEASED (Type or Print)<br><b>Deborah</b>   | (First)<br><b>Ann</b>            | (Middle)<br><b>Gjerulff</b>  | (Last)  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH<br><b>July 9, 1954</b>                                 |
| 9. AGE last birthday<br><b>3</b> yrs.   |                                  | 10. DATE OF DEATH<br><b>July 14, 1955</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b> |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |                                  | 13. FATHER'S NAME<br><b>Richard M. Gjerulff</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Rita Weller</b>  |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |   |
| 16. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT AND ADDRESS<br><b>Richard M. Gjerulff</b>  |   |

|  |  |   |
|--|--|---|
| 18. MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs</b>  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><b>724: asphyxia (accidental)</b><br>Immediate cause (a) Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)   |  |   |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><b>None</b>   |  |   |
| 19a. DATE OF OPERATION<br><b>None</b>  | 19b. MAJOR FINDINGS OF OPERATION<br><b>None</b>  | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>       |
| 21. PRIMARY CAUSE OF DEATH<br>TIME (Month) (Day) (Year) (Hour)<br><b>July 14 '55 8 a.m.</b>  | PLACE (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b><br>INJURY<br>INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | (CITY OR TOWN)<br><b>Pikesville</b><br>(COUNTY)<br><b>Balt.</b><br>(STATE)<br><b>Ind.</b> |
| 22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, or a combination thereof, and find that said deceased died of the following cause: natural causes, accident, suicide, homicide, undetermined.<br><b>accident</b><br>SIGNATURE<br><b>K. L. Coples</b><br>(Degree or title)<br><b>79.4</b><br>ADDRESS<br><b>Rustertown, Ind.</b><br>DATE SIGNED<br><b>7-14-55</b> |  |   |
| 23. FUNERAL DIRECTOR<br>NAME<br><b>Frank H. Jewell</b><br>ADDRESS<br><b>Pikesville</b>   | 24. DATE OF BURIAL OR CREMATION<br><b>7-14-55</b><br>LOCATION (City, town, or county)<br><b>Pikesville</b><br>(State)<br><b>Ind.</b>   |   |

MARGIN RESERVED FOR BINDING

Supply every item of information carefully. The correct cause of death is especially important. Physicians: write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

Item 2, File GLF4 7-14-55 et

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH:<br>COUNTY <u>Baltimore</u> 19 MARYLAND  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>Maryland</u> COUNTY <u>Balto.</u>  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><input checked="" type="checkbox"/> TOWN <u>Edgemere.</u>   |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><input checked="" type="checkbox"/> TOWN <u>Edgemere</u> |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>At Home</u>  |                                  | STREET ADDRESS (If rural, give location)<br><u>Box 370 North Point Rd</u>   |  |
| 3. NAME OF DECEASED<br>(Type or Print) (First) (Middle) (Last)<br><u>Mary</u> <u>Golombowski</u>   |                                  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>JULY</u> <u>7TH</u> <u>1955</u>   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>Widow</u>  | 8. DATE OF BIRTH<br><u>Oct 18 1912</u> |
| 9. AGE (last birthday)<br><u>43</u> yrs.   |                                  | 10. BIRTHPLACE (State or foreign country)<br><u>Poland</u>  |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>Poland</u>   |  |
| 13. FATHER'S NAME<br><u>John Wajcik</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>unknown</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><u>China Kane Box 370 North Point Road</u>   |  |
| 17. MEDICAL CERTIFICATION  |                                  |   |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                  |   | INTERVAL BETWEEN ONSET AND DEATH       |
| (a) Immediate cause<br><u>Cerebral Hemorrhage</u>  |                                  |   | <u>5 minutes</u>                       |
| (b) Antecedent cause(s)<br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last<br><u>Atherosclerotic Cardiovascular Disease</u>   |                                  |   | <u>?</u>                               |
| (c) OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |                                  |   |  |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION  |  |
| 21. ACCIDENT (Specify)<br>SUICIDE<br>HOMICIDE  |                                  | PLACE (Home, farm, factory, street, office bldg., etc.)<br>INJURY   |  |
| (CITY OR TOWN)   |                                  | (COUNTY)  |  |
| (STATE)  |                                  | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| TIME (Month) (Day) (Year) (Hour)<br>OF INJURY  |                                  | INJURY OCCURRED<br>While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>                              |  |
| HOW DID INJURY OCCUR?  |                                  |   |  |
| 22. I hereby certify that I attended the deceased from <u>July 6, 1955</u> , to <u>July 7, 1955</u> , that I last saw the deceased alive on <u>July 6, 1955</u> , and that death occurred at <u>2:45</u> p.m., from the causes and on the date stated above. |                                  |   |  |
| SIGNATURE<br><u>David Owens, M.D.</u>  |                                  | DATE SIGNED<br><u>7/7/55</u>  |  |
| 23. BURIAL, CREMATION REMOVAL (Specify)<br><u>Burial</u>   |                                  | DATE THEREOF<br><u>7/11/55</u>  |  |
| NAME OF CEMETERY OR CREMATORIAL<br><u>Sacred Heart of Mary</u>   |                                  | LOCATION (City, town, or county) (State)<br><u>German Hill Rd</u>   |  |
| DATE REC'D BY LOCAL REG.<br><u>7-8-55</u>  |                                  | 24. FUNERAL DIRECTOR<br><u>George A. Weber 705 S. Ann St.</u>   |  |



6335

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH:  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |   |
| COUNTY <i>Baltimore County</i>  | MARYLAND  | STATE <i>Maryland</i>  | COUNTY <i>Lt.</i>                                     |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>51 Relay</i>                  | LENGTH OF STAY (in this place) <i>2 months 9 days</i> | CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Sorey, Md.</i> | <i>ix-2</i>   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>70 Relay Hill Hospital</i>                                   |   | STREET ADDRESS (If rural give location) <i>Forest Road.</i>                                | <i>✓</i>  |
| 3. NAME OF DECEASED:  |   | 4. DATE OF DEATH:  |   |
| (First) <i>Louis</i>  | (Middle)  | (Last) <i>Gotthelf</i>   | (Month) <i>July</i> (Day) <i>7</i> (Year) <i>1955</i> |
| 5. SEX: <i>Male</i>   | 6. COLOR OR RACE: <i>White</i>                        | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>                           | 8. DATE OF BIRTH: <i>11/26/1877</i>                   |
| 9. AGE last birthday: <i>77</i> yrs.  |   | 10. UNDER 1 YEAR: <i>Months</i> <i>Days</i> <i>Hours</i> <i>Min.</i>                       |   |
| 11a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>Cabaret</i> |   | 11b. KIND OF BUSINESS OR INDUSTRY: <i>Building</i>   |   |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |   | 13. BIRTHPLACE (State or foreign country): <i>New York</i>                                 |   |
| 14. FATHER'S NAME: <i>Leon Gotthelf</i>   |   | 15. MOTHER'S MAIDEN NAME: <i>Elizabeth Peder</i>   |   |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)  |   | 17. SOCIAL SECURITY No.:   |   |
| 18. IF Yes, give war or dates of service:   |   | 19. INFORMANT & ADDRESS: <i>Mrs. Richard Heyding - Forest Rd. Sorey, Md.</i>               |   |

|  |                                  |   |
|--|----------------------------------|---|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                  | Interval Between Onset And Death: <i>4 months</i>                     |
| Immediate cause (a) <i>420.0 Congestive heart failure</i>  |                                  |   |
| Antecedent causes (s) (b) <i>Arteriosclerotic heart disease</i>  |                                  |   |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)  |                                  |   |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Arricular fibrillation</i> |                                  | <i>?</i>  |
| 19a. DATE OF OPERATION:  | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |

|  |   |                       |          |         |
|--|---|-----------------------|----------|---------|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)    | PLACE (Home, farm, factory, street, office bldg., etc.)   | (CITY OR TOWN)        | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED White at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | HOW DID INJURY OCCUR? |          |         |

|  |                       |  |                                  |             |
|--|-----------------------|--|----------------------------------|-------------|
| 22. I hereby certify that I attended the deceased from <i>3/29/1955</i> , to <i>7/7/1955</i> , that I last saw the deceased alive on <i>7/6/1955</i> , and that death occurred at <i>4:50 AM</i> from the causes and on the date stated above. |                       |  |                                  |             |
| SIGNATURE <i>Samuel J. Tushy M.D.</i>  |                       | ADDRESS <i>7/7/55</i>                            |                                  | DATE SIGNED |
| 23. BURIAL, CREMATION, REMOVAL (Specify)   | DATE THEREOF          | NAME OF CEMETERY OR CREMATORY                    | LOCATION (City, town, or county) | (State)     |
| <i>Burial</i>  | <i>7/9/55</i>         | <i>Woodlawn</i>                                  | <i>Woodlawn, Md.</i>             |             |
| DATE REC'D BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR'S ADDRESS                   |                                  |             |
| <i>7-8-55</i>  | <i>D. D. C.</i>       | <i>Adm. Eustice E. Donovan - 3818 Roland Ave</i> |                                  |             |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6336  
CERTIFICATE OF DEATH

Reg. Dist. No. 30

|   |  |  |                   |
|---|--|--|-------------------|
| 1. PLACE OF DEATH:  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                   |
| COUNTY <b>Baltimore</b>   | MARYLAND   | STATE <b>Maryland</b>  | COUNTY            |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <b>52 Catonsville</b>   | LENGTH OF STAY (in this place)<br><b>51yr1mo29days</b> | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <b>Baltimore</b>   | <b>3Y-1-4</b>     |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>14 Spring Grove State Hospital</b>  |  | STREET ADDRESS (If rural give location)  |                   |
| 3. NAME OF DECEASED: (Type or Print)  |  | 4. DATE (Month) (Day) (Year)   |                   |
| <b>Joseph Guerin</b>  |  | <b>July 26, 19 55</b>  |                   |
| 5. SEX:   | 6. COLOR OR RACE:                                      | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH: |
| <b>Male</b>   | <b>White</b>   | <b>Single</b>  | <b>1881</b>       |
| 9. AGE last birthday  |  | 10. DATE OF DEATH: <b>July 26, 19 55</b>   |                   |
| <b>74? yrs</b>  |  | <b>74? yrs</b>   |                   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  |  | 10B. KIND OF BUSINESS OR INDUSTRY:   |                   |
| <b>Teacher</b>  |  |  |                   |
| 11. BIRTHPLACE (State or foreign country):  |  | 12. CITIZEN OF WHAT COUNTRY?   |                   |
| <b>Austria</b>  |  | <b>Austria</b>   |                   |
| 13. FATHER'S NAME:  |  | 14. MOTHER'S MAIDEN NAME:  |                   |
| <b>Unknown</b>  |  | <b>Unknown</b>   |                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |                   |
| <b>Unknown</b>  |  | <b>Unknown</b>   |                   |
| 17. INFORMANT & ADDRESS:  |  | 18. MEDICAL CERTIFICATION  |                   |
| <b>Records Spring Grove State Hospital</b>  |  | 19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                   |
| I   |  | INTERVAL BETWEEN ONSET AND DEATH   |                   |
| IMMEDIATE CAUSE   |  | (A) <b>Cerebral hemorrhage</b>   |                   |
| ANTECEDENT CAUSE (B):   |  | DUE TO   |                   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |  | (B) <b>Subacute vegetative endocarditis</b>  |                   |
|   |  | DUE TO   |                   |
|   |  | (C)  |                   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |                   |
| 19A. DATE OF OPERATION:   |  | 19B. MAJOR FINDINGS OF OPERATION   |                   |
|   |  |  |                   |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)   |                   |
|   |  | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |                   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                   |
|   |  | 21F. HOW DID INJURY OCCUR?   |                   |
| 22. I hereby certify that I attended the deceased from <b>5-27-</b> , 19 <b>04</b> to <b>7-26-</b> , 19 <b>55</b> that I last saw the deceased alive on <b>7-26-</b> , 19 <b>55</b> , and that death occurred at <b>8:10 P.M.</b> , from the causes and on the date stated above. |  |  |                   |
| SIGNATURE <b>S. Wachler</b>   |  | DATE SIGNED <b>Spring Grove State Hospital</b>   |                   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | NAME OF CEMETERY OR CREMATORY  |                   |
| <b>Burial</b>   |  | <b>Spring Grove State Hospital</b>   |                   |
| DATE REC'D BY LOCAL REGISTRAR <b>8-2-55</b>   |  | REGISTRAR'S SIGNATURE <b>V.E. Harry</b>  |                   |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |                   |
| <b>Spring Grove State Hospital</b>  |  | <b>Catonsville 28, Maryland</b>  |                   |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





6337

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                           |  |                                 |
|---|---------------------------|--|---------------------------------|
| 1. PLACE OF DEATH:  |                           | 2. USUAL RESIDENCE (HOME) OF DECEASED.   |                                 |
| COUNTY <u>Baltimore</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR <u>52 Catonsville</u><br>TOWN <u>12 days</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp.</u>                     |                           | STATE <u>Maryland</u> COUNTY<br>CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR <u>Baltimore</u><br>TOWN <u>3401 4</u><br>STREET ADDRESS (If rural give location)<br><u>2200</u> |                                 |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><u>Madeline Benson Gwynn</u>  |                           | 4. DATE OF DEATH: (Month) (Day) (Year)<br><u>July 12 1955</u>  |                                 |
| 5. SEX <u>1</u>   | 6. COLOR OR RACE <u>1</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>2</u>   | 8. DATE OF BIRTH <u>2, 1901</u> |
| 9. AGE last birthday <u>4</u> VIA. Months Days Hours Min.   |                           | 10. BIRTHPLACE (State or foreign country): <u>Delaware</u>   |                                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Housewife</u>  |                           | 10B. KIND OF BUSINESS OR INDUSTRY:   |                                 |
| 11. BIRTHPLACE (State or foreign country): <u>Delaware</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>US</u>   |                                 |
| 13. FATHER'S NAME:  |                           | 14. MOTHER'S MAIDEN NAME:  |                                 |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |                           | 16. SOCIAL SECURITY NO.  |                                 |
| 17. INFORMANT & ADDRESS:<br><u>Hospital rec.</u>  |                           | 18. MEDICAL CERTIFICATION  |                                 |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><u>332X</u><br>IMMEDIATE CAUSE (A) <u>Cerebral</u><br>ANTECEDENT CAUSE (B) DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST<br>(C)                |                           | INTERVAL BETWEEN ONSET AND DEATH   |                                 |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                           |  |                                 |
| 19A. DATE OF OPERATION: <u>U</u>  |                           | 19B. MAJOR FINDINGS OF OPERATION   |                                 |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                           |  |                                 |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                                 |
| 21C. WHERE DID (City or town) (County) (State)<br>INJURY OCCUR?   |                           |  |                                 |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                           | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>M. at work <input type="checkbox"/> at work <input type="checkbox"/>   |                                 |
| 21F. HOW DID INJURY OCCUR?  |                           |  |                                 |
| 22. I hereby certify that I attended the deceased from <u>1 July, 1955</u> , to <u>12 July, 1955</u> , that I last saw the deceased alive on <u>12 July, 1955</u> , and that death occurred at <u>2:55 AM</u> , from the causes and on the date stated above. |                           |  |                                 |
| SIGNATURE <u>Louise Frances Woodward</u>  |                           | ADDRESS <u>M.D. Spring Grove State Hospital Catonsville</u> DATE SIGNED <u>7-12-55</u>   |                                 |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |                           | DATE THEREOF <u>July 14-55</u> NAME OF CEMETERY OR CREMATORY <u>Lorraine Woodson</u> LOCATION (City, town, or county) (State)  |                                 |
| DATE REC'D BY LOCAL REGISTRAR <u>7-12-55</u>  |                           | REGISTRAR'S SIGNATURE <u>A.W. Hedrich</u> 24. FUNERAL DIRECTOR <u>Chas. W. Munn Co. 108 W. 11th St.</u> ADDRESS  |                                 |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6339

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

## 1. PLACE OF DEATH:

COUNTY **BALTIMORE** MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **MIDDLE RIVER** LENGTH OF STAY (In this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **22 MAXWELL RD.**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MD.** COUNTY **BALTO.**  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **MIDDLE RIVER**  
 STREET ADDRESS (If rural, give location) **22 MAXWELL ROAD**

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
**MARY HARRELL**

4. DATE OF DEATH: (Month) (Day) (Year)  
**JULY 14 1955**

5. SEX:  
**FEMALE**

6. COLOR OR RACE:  
**WHITE**

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)  
**WIDOWED**

8. DATE OF BIRTH:  
**3-20-86**

9. AGE last birthday: (If under 1 year) (If under 24 hrs.)  
**69 yrs. 3 Months 24 Days**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**AT HOME**

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):  
**NORTH CAROLINA**

12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

**WILLIAM MOSLEY**

## 14. MOTHER'S MAIDEN NAME:

**SALLIE BUCHANAN**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

**443X**  
 Immediate cause

(a) DUE TO

**Cerebral Vascular accident**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

**H-T. C.V. D.**

(c)

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-11**, 19**55**, to **7-14**, 19**55** that I last saw the deceased alive on **7-13**, 19**55**, and that death occurred at **6 A.M.**, from the causes and on the date stated above.  
 SIGNATURE **Marvin Rumber, M.D.** (DEGREE OR TITLE) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. **7-14-55**

REGISTRAR'S SIGNATURE

**Edith Hurley**

24. FUNERAL DIRECTOR

ADDRESS

**JOHN G. CONNELLY ESSEX, MD.**

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

1964

10

11

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6340

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN FORT HOWARDLENGTH OF STAY  
(In this place)1 Day  
12 hrs 45 minHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSVETERANS ADMINISTRATION HOSPITAL

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR  
TOWN BALTIMORESTREET  
ADDRESS

(If rural give location)

1404 DARLEY AVENUE3. NAME OF  
DECEASED

(Type or Print)

(First)

JOHN

(Middle)

A.

(Last)

HATCH

4. DATE (Month)

OF

DEATH. JULY 31

(Day)

(Year)

19 55

## 5. SEX

MALE6. COLOR OR  
RACE:WHITE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)MARRIED

## 8. DATE OF BIRTH

2/3/93 or 2/3/95

## 9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS

Months Days Hours Min.

62 or 605 2810A. USUAL OCCUPATION Give kind of  
work done during most of working life,  
even if retired: PRINTER10B. KIND OF BUSINESS  
OR INDUSTRY  
YOUNG & SELDEN CO.

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND12. CITIZEN OF WHAT  
COUNTRY?U.S.A.

## 13. FATHER'S NAME:

JAMES M. HATCH13A. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) If Yes, give year or dates  
of service: YES -I

13B. SOCIAL SECURITY NO.

212 07 3240

## 14. MOTHER'S MAIDEN NAME.

KATHERINE WHEATEN

## 17. INFORMANT &amp; ADDRESS.

CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.

## 15. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

157X

## IMMEDIATE CAUSE

## ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.(A) CARCINOMA OF THE HEAD OF THE PANCREAS  
EXTENSIVE WITH METASTASES TO THE LIVER(B)  
DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH5 MONTHSII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION

3/25/55

## 19B. MAJOR FINDINGS OF OPERATION

CARCINOMA OF PANCREAS

## 20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR? (County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURYVA M21E. INJURY OCCURRED  
While ☐ Not while ☐  
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JULY 30, 1955, to JULY 31, 1955, that I last saw the deceasedand on  
SIGNATUREAbraham A. Polachek, M.D.23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)BURIAL

DATE THEREOF

Aug. 3rd. 1955

NAME OF CEMETERY OR CREMATORY

BALTIMORE NATIONAL

LOCATION (City, town, or county)

BALTIMORE, MD.

(State)

DATE REC'D BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

George J. Ruth Inc. Funeral Home  
1733-35 Harford Ave. Balto, Maryland

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6341

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. PLACE OF DEATH:  |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                |  |   |   |
| COUNTY Baltimore  |  | MARYLAND   |  | STATE Maryland  |  | COUNTY Baltimore                                |   |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  |  | LENGTH OF STAY (in this place)   |  | CITY (If outside corporate limits, write RURAL and give nearest town) |  |   |   |
| X TOWN Owings Mills   |  | 44 yrs.  |  | OR TOWN X   |  |   |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Rosewood Training School  |  |  |  | STREET ADDRESS (If rural, give location) St. Vincent's Orphanage      |  |   |   |
| 3. NAME OF DECEASED: (Type or Print)  |  | (First) John   |  | (Middle)  |  | (Last) Hatfield                                 |   |
| 5. SEX: male  |  | 6. COLOR OR RACE: white  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single              |  | 8. DATE OF BIRTH: 1902                          |   |
|   |  |  |  | 9. AGE last birthday: 53 yrs.   |  | 4. DATE OF DEATH: 7 16 19 55                    |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  |  | 10b. KIND OF BUSINESS OR INDUSTRY:   |  | 11. BIRTHPLACE (State or foreign country):                            |  | 12. CITIZEN OF WHAT COUNTRY?                    |   |
| -   |  | -  |  | Maryland  |  | U.S.A.  |   |
| 13. FATHER'S NAME: Unknown  |  |  |  | 14. MOTHER'S MAIDEN NAME: Unknown                                     |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):   |  | 16. SOCIAL SECURITY No.:   |  | 17. INFORMANT & ADDRESS:  |  |   |   |
| - (If Yes, give war or dates of service)  |  | -  |  | Rosewood Records  |  |   |   |
| 18. MEDICAL CERTIFICATION   |  |  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH                                    |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  |  |  |  |   |  |   |   |
| 300.4 Immediate cause (a) Acute Cardiac Failure   |  |  |  |   |  |   | 18 hrs.   |
| Antecedent cause(s) (b) Grand Mal Epilepsy  |  |  |  |   |  |   | since 3 yrs. old  |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)  |  |  |  |   |  |   |   |
| II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Chronic Psychosis-Schizophrenia Reaction  |  |  |  |   |  |   | many years  |
| 19a. DATE OF OPERATION:   |  |  |  | 19b. MAJOR FINDINGS OF OPERATION:                                     |  |   | 20. AUTOPSY?  |
|   |  |  |  |   |  |   | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21. ACCIDENT (Specify)  |  | PLACE (Home, farm, factory, street, OF office bldg., etc.)                           |  | (CITY OR TOWN)  |  | (COUNTY) (STATE)                                |   |
| SUICIDE   |  | INJURY   |  |   |  |   |   |
| HOMICIDE  |  |  |  |   |  |   |   |
| TIME (Month) (Day) (Year) (Hour)  |  | INJURY OCCURRED  |  | HOW DID INJURY OCCUR?   |  |   |   |
| OF INJURY   |  | M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  |   |  |   |   |
| 22. I hereby certify that I attended the deceased from 3/21 19 55, to 7/16 19 55, that I last saw the deceased alive on 7/16 19 55, and that death occurred at 5:55 a.m., from the causes and on the date stated above. |  |  |  |   |  |   |   |
| SIGNATURE   |  |  |  | (DEGREE OR TITLE)   |  | ADDRESS   |   |
| Viola B. Johns  |  |  |  | M.D.  |  | Rosewood State Tr. Sch. Owings Mills Md 7/18/55 |   |
| 23. BURIAL, CREMATION REMOVAL (Specify):  |  | DATE THEREOF   |  | NAME OF CEMETERY OR CREMATORY   |  | LOCATION (City, town, or county) (State)        |   |
| 7/21/55   |  | 7/21/55  |  | University Medical  |  | Baltimore Md                                    |   |
| DATE REC'D BY LOCAL REG.  |  | REGISTRAR'S SIGNATURE  |  | 24. FUNERAL DIRECTOR  |  | ADDRESS   |   |
| 7-21-55   |  | Mary B. Elmer  |  | Frances A. Hensley  |  | 578 W. Biggle St.                               |   |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FORWARD

100-100

100-100



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

Item 12, File 164 R-1-55 at

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH:<br>COUNTY <u>Balto Co</u> MARYLAND  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>223 S. Strickland</u> COUNTY <u>Balto Ind</u> |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>                     |   | CITY (If outside corporate limits, write RURAL and give nearest town) <u>3001-4</u>              |  |
| TOWN <u>Arbutus</u>  |   | TOWN   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5544 Ashbourne Rd.</u>                                      |   | STREET ADDRESS (If rural give location)  |  |
| 3. NAME OF DECEASED (First) (Middle) (Last)<br><u>PATRICK J.</u> <u>HICKEY</u>                           |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>7</u> <u>17</u> <u>1955</u>                          |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>                                  | 8. DATE OF BIRTH <u>Nov 11 1915</u>                      |
| 9. AGE last birthday <u>39</u> yrs.  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer B &amp; O. R.R.</u> | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country) <u>Ireland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   | 13. FATHER'S NAME <u>John Hickey</u>  | 14. MOTHER'S MAIDEN NAME <u>Maria Coolahan</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. <u>None</u>   | 17. INFORMANT <u>Wm Hickey 2421 Evans drive Ind.</u>   |  |

|   |                                  |  |
|---|----------------------------------|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                  | INTERVAL BETWEEN ONSET AND DEATH   |
| Immediate cause <u>592x Nephritic Coma.</u>   |                                  | <u>2 day</u>   |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last            |                                  |  |
| (a) <u>Senility</u>   |                                  |  |
| (b) <u>Chronic myocarditis from nephritis</u>   |                                  |  |
| (c) <u>Hyperstatic pneumonia. Senility</u>  |                                  |  |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death |                                  |  |
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|  |   |                       |          |         |
|--|---|-----------------------|----------|---------|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)    | PLACE (Home, farm, factory, street, OF office bldg., etc.)  | (CITY OR TOWN)        | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |          |         |

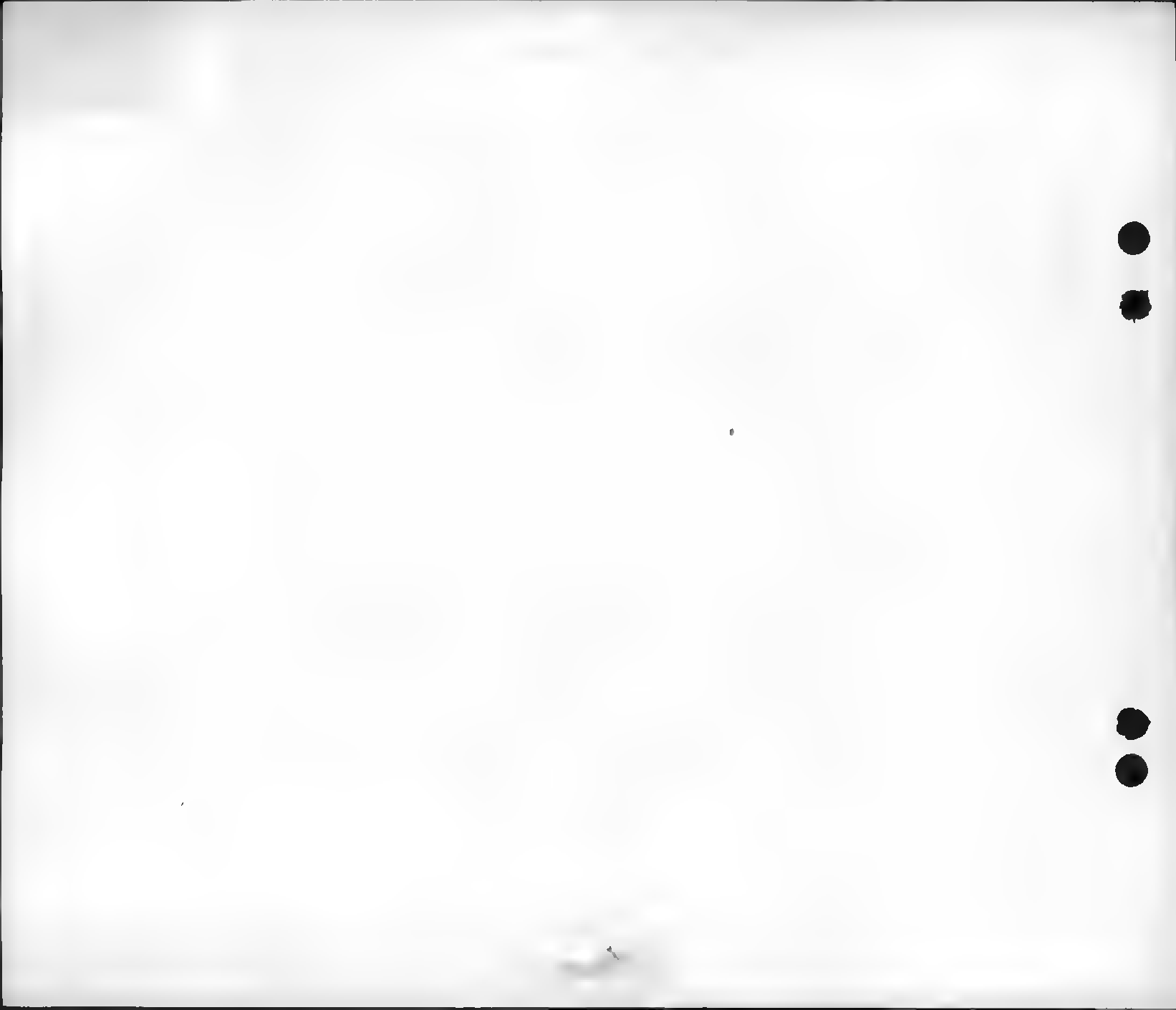
22. I hereby certify that I attended the deceased from May, 1955, to July 16, 1955, that I last saw the deceased alive on July 17, 1955, and that death occurred at 7:30 m., from the causes and on the date stated above.

|   |                             |   |  |
|---|-----------------------------|---|--|
| SIGNATURE <u>W. Calais</u>                            | (Degree or title) <u>MD</u> | ADDRESS <u>4 N. Fulton Ave Md</u>                       | DATE SIGNED  |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | DATE THEREOF <u>7/20/55</u> | NAME OF CEMETERY OR CREMATORY <u>New Hope</u>           | LOCATION (City, town, or county) <u>Balto</u> (State) <u>Ind</u> |
| DATE REC'D BY LOCAL REG.                              | REGISTRAR'S SIGNATURE       | 24. FUNERAL DIRECTOR <u>Robt C. &amp; P. M. Walters</u> | ADDRESS <u>121 S. Strickland</u>                                 |

Balto. 23. Ind.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## CERTIFICATE OF DEATH

Reg. Dist. No.

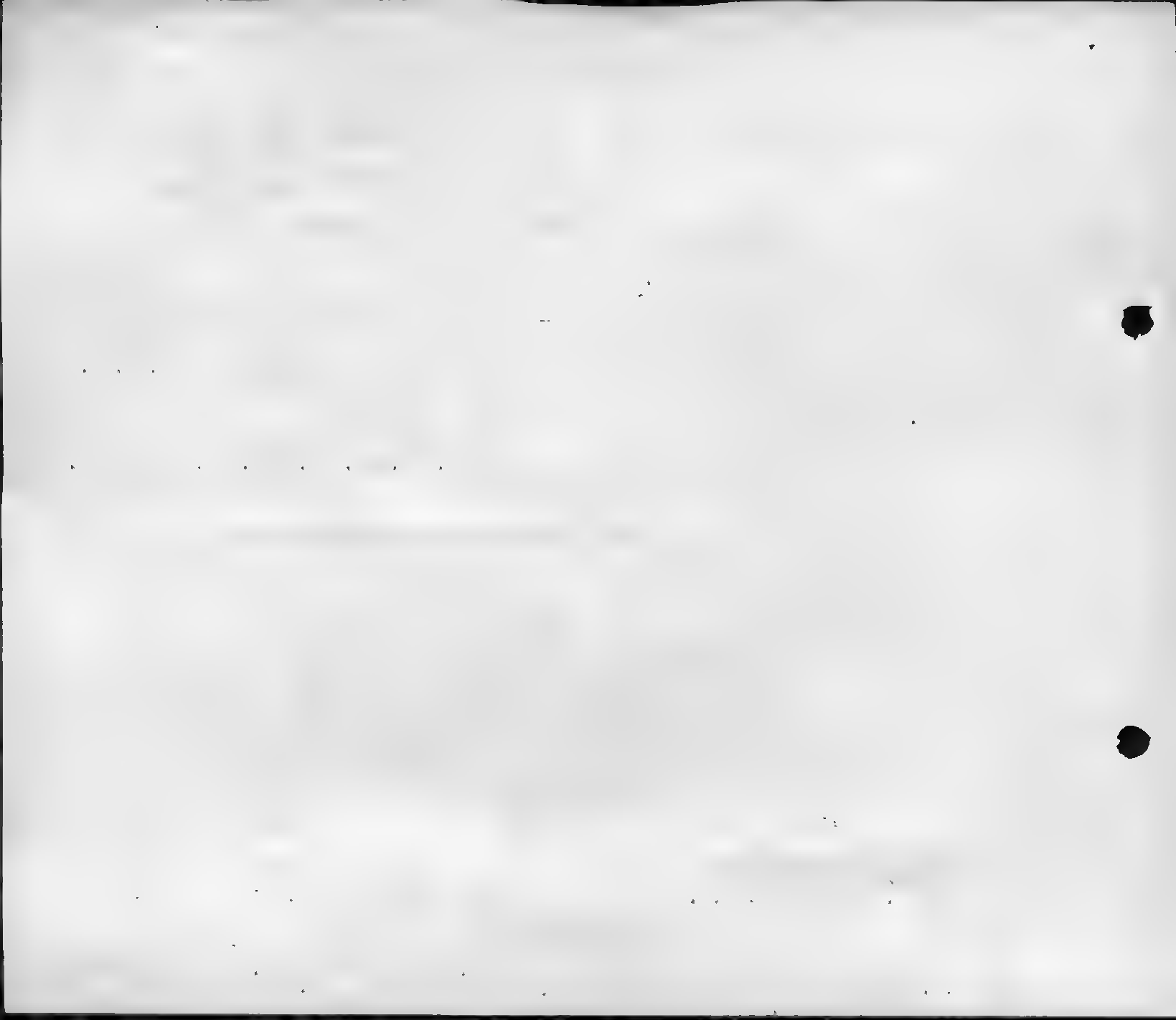
|   |                                |   |                                  |
|---|--------------------------------|---|----------------------------------|
| 1. PLACE OF DEATH   |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED                                 |                                  |
| COUNTY <b>BALTIMORE</b>   | MARYLAND                       | STATE <b>MARYLAND</b>   | COUNTY <b>ANNE ARUNDEL</b>       |
| CITY (If outside corporate limits, write RURAL, and give nearest town)  | LENGTH OF STAY (In this place) | CITY (If outside corporate limits, write RURAL and give nearest town) |                                  |
| <b>X</b> TOWN <b>FORT HOWARD</b>  | <b>5182 DAYS</b>               | TOWN <b>GLEN BURNIE</b>   |                                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                                | STREET ADDRESS (If rural give location)                               |                                  |
| <b>VETERANS ADMINISTRATION HOSPITAL</b>   |                                | <b>508 MANOR ROAD</b>   |                                  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |                                | 4. DATE (Month) (Day) (Year)  |                                  |
| <b>JAMES E. HILLARY</b>   |                                | DATE OF DEATH: <b>JULY 27 1955</b>                                    |                                  |
| 5. SEX: <b>MALE</b>   | 6. COLOR OR RACE: <b>WHITE</b> | 7. SINGLE MARRIED, WIDOWED, DIVORCED: <b>DIVORCED</b>                 | 8. DATE OF BIRTH: <b>12-2-86</b> |
| 9. AGE last birthday: <b>68</b> yrs.  |                                | 10. AGE last birthday: IF UNDER 1 YEAR Months Days Hours Min.         |                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                | 10B. KIND OF BUSINESS OR INDUSTRY:                                    |                                  |
| <b>SEAMAN</b>   |                                |   |                                  |
| 11. BIRTHPLACE (State or foreign country):  |                                | 12. CITIZEN OF WHAT COUNTRY?  |                                  |
| <b>BALTIMORE, MARYLAND</b>  |                                | <b>U. S. A.</b>   |                                  |
| 13. FATHER'S NAME:  |                                | 14. MOTHER'S MAIDEN NAME.   |                                  |
| <b>JAMES E. HILLARY</b>   |                                | <b>MARY MAE CALVERT</b>   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)  |                                | 16. SOCIAL SECURITY NO.   |                                  |
| <b>YES WW-I</b>   |                                | <b>Unknown</b>  |                                  |
| 17. INFORMANT & ADDRESS.  |                                |   |                                  |
| <b>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</b>  |                                |   |                                  |
| 18. MEDICAL CERTIFICATION   |                                | INTERVAL BETWEEN ONSET AND DEATH                                      |                                  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                |   |                                  |
| IMMEDIATE CAUSE (A) <b>9317 SENILITY; TERMINAL MILD HEAT STROKE</b>   |                                | <b>UNKNOWN</b>  |                                  |
| ANTECEDENT CAUSE (B) <b>DUE TO</b>  |                                |   |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |                                |   |                                  |
| (C) <b>DUE TO</b>   |                                |   |                                  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                                |   |                                  |
| 19A. DATE OF OPERATION:   |                                | 19B. MAJOR FINDINGS OF OPERATION                                      |                                  |
|   |                                |   |                                  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                |   |                                  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                | 21B. PLACE (Home, farm, factory street, office bldg., etc.)           |                                  |
| 21C. WHERE DID (City or town) (County) (State)  |                                | 21D. TIME (Month) (Day) (Year) (Hour)                                 |                                  |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                      |                                | 21F. HOW DID INJURY OCCUR?  |                                  |
| 22. I hereby certify that I attended the deceased from <b>JUNE 6, 1955</b> to <b>JULY 27, 1955</b> , and that death occurred at <b>11:50 M.</b> from the causes and on the date stated above. |                                |   |                                  |
| ADDRESS   |                                | DATE SIGNED   |                                  |
| <b>WILLIAM B. VANDEGRIFT, M.D.</b>  |                                | <b>M. D. VAH, FORT HOWARD, MARYLAND 7-29-55</b>                       |                                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                                | NAME OF CEMETERY OR CREMATORY   |                                  |
| <b>REMOVAL</b>  |                                | <b>ARLINGTON NATIONAL</b>   |                                  |
| DATE REC'D BY LOCAL REGISTRAR   |                                | LOCATION (City, town, or county) (State)                              |                                  |
| <b>AUG. 1, 1955</b>   |                                | <b>FORT MYER, VIRGINIA</b>  |                                  |
| 24. FUNERAL DIRECTOR  |                                | ADDRESS   |                                  |
| <b>WM. COOK-BLIGHT, INC. 6009 HARFORD RD. BALTIMORE 14, MD.</b>   |                                |   |                                  |

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SHIPPED



6342

## CERTIFICATE OF DEATH

Reg. Dist. No. 3

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH:  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |   |
| COUNTY <u>Baltimore</u>   | MARYLAND   | STATE <u>Maryland</u>  | COUNTY  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>  | LENGTH OF STAY (in this place)   | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor Convalescent Home</u>   |  | STREET ADDRESS (If rural give location) <u>1111 N. Port Street</u>                     |   |
| 3. NAME OF DECEASED: (First) <u>Grace</u> (Middle) <u>N.</u> (Last) <u>Reifmann</u>   |  | 4. DATE (Month) (Day) (Year) OF DEATH: <u>July 17 1955</u>                             |   |
| 5. SEX: <u>Female</u>   | 6. COLOR OR RACE: <u>Caucasian</u>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>MARRIED</u>                                  | 8. DATE OF BIRTH: <u>Feb. 13, 1899</u>                                |
| 9. AGE last birthday: <u>56</u> yrs   |  | 10. UNDER 1 YEAR: Months Days  | 11. UNDER 24 HRS: Hours Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY:   | 11. BIRTHPLACE (State or foreign country): <u>Martinsburg, W. Va.</u> |
| 13. FATHER'S NAME: <u>Arthur N. Stevens</u>   |  | 14. MOTHER'S MAIDEN NAME: <u>Laura E. Schaefer</u>                                     |   |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |   |
| 15. SOCIAL SECURITY NO. <u>---</u>  |  | 17. INFORMANT & ADDRESS: <u>A. Christian Hays - 4810 Frankfort Ave</u>                 |   |
| 15. MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |   |
| 443 X<br>IMMEDIATE CAUSE  |  | (A) <u>Cerebral hemorrhage</u>   |   |
| ANTECEDENT CAUSE (S)  |  | DUE TO   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |  | (B) <u>hypertension</u>  |   |
|   |  | DUE TO   |   |
|   |  | (C) <u>arteriosclerosis</u>  |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |   |
| 19A. DATE OF OPERATION: <u>0</u>  | 19B. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 | 21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)                           |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <u>1955</u> , to <u>July 17, 1955</u> , that I last saw the deceased alive on <u>6</u> , 19 <u>55</u> , and that death occurred at <u>4:45 P. M.</u> from the causes and on the date stated above. |  |  |   |
| SIGNATURE <u>G. C. Hedrick</u>  |  | DATE SIGNED <u>M. D. 7/18/55</u>   |   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  | DATE THEREOF   | NAME OF CEMETERY OR CREMATORY  | LOCATION (City, town, or county) (State)                              |
|   | <u>7-20-55</u>   | <u>Forest Ridge Cem.</u>   | <u>Balta. Md.</u>   |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>G. C. Hedrick</u>  | 24. FUNERAL DIRECTOR <u>John C. Miller Inc. - 2431 E. O'Harra St.</u>                                  | ADDRESS  |   |



MARYLAND

STATE DEPARTMENT OF HEALTH

6343

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH-<br>COUNTY <b>Baltimore</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <b>Maryland</b> COUNTY <b>Baltimore</b>                        |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <b>Reisterstown</b> LENGTH OF STAY (in this place) <b>10 yrs.</b>  |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <b>Reisterstown</b>           |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>123 Chatsworth Ave.</b>  |                                  | STREET ADDRESS (If rural, give location) <b>123 Chatsworth Ave.</b>  |  |
| 3. NAME OF DECEASED (First) (Middle) (Last)<br><b>Wilma Mann Houck</b>  |                                  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>July 16, 1955</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>July 28, 1913</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE last birthday<br><b>41</b> yrs.   |
| 11. FATHER'S NAME<br><b>Orville Mann</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 13. MOTHER'S MAIDEN NAME<br><b>Elizabeth E. Addleman</b>  |                                  | 14. INFORMANT AND ADDRESS<br><b>Charles E. Houck Jr. Reisterstown, Md.</b>                                     |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)   |                                  | 16. SOCIAL SECURITY No.<br><b>219-14-9825</b>  |  |
| 18. MEDICAL CERTIFICATION   |                                  |  |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                  |  | INTERVAL BETWEEN ONSET AND DEATH         |
| 190x Immediate cause (a) <b>Generalized melanomatosis</b>   |                                  |  | <b>10 mo.</b>                            |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>melanoma of lg. (rt.)</b>   |                                  |  | <b>19 mo.</b>                            |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><b>None.</b>   |                                  |  |  |
| 19a. DATE OF OPERATION<br><b>10-29-53.</b>  |                                  | 19b. MAJOR FINDINGS OF OPERATION<br><b>Melanocarcinoma (rt. lg.)</b>   |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)<br><b>None.</b>   |                                  | PLACE (Home, farm, factory, street, OF office bldg., etc.)<br><b>None.</b>                                     |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>None.</b>  |                                  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> <b>None.</b> |  |
| HOW DID INJURY OCCUR?<br><b>None.</b>   |                                  |  |  |
| 22. I hereby certify that I attended the deceased from <b>10-2</b> , 19 <b>53</b> , to <b>7-16</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>7-14</b> , 19 <b>55</b> , and that death occurred at <b>4 P.</b> m., from the causes and on the date stated above. |                                  |  |  |
| SIGNATURE<br><b>D. S. Caples, M.D.</b>  |                                  | ADDRESS<br><b>Reisterstown, Md.</b>  |  |
| DATE SIGNED<br><b>7-18-55</b>   |                                  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | DATE<br><b>July 19, 1955</b>   |  |
| NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>   |                                  | LOCATION (City, town, or county) (State)<br><b>Baltimore County</b>  |  |
| DATE REC'D BY LOCAL REG.<br><b>7-19-55</b>  |                                  | REGISTRAR'S SIGNATURE<br><b>Mary B. Eline.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>J. F. Eline &amp; Sons, Reisterstown, Md.</b>  |                                  | ADDRESS<br><b>J. F. Eline &amp; Sons, Reisterstown, Md.</b>  |  |

5 100-100

100 100 100



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

|   |   |  |  |                                       |  |                  |  |        |      |       |      |
|---|---|--|--|---------------------------------------|--|------------------|--|--------|------|-------|------|
| <b>1. PLACE OF DEATH:</b><br>COUNTY <u>Baltimore</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 213 Westmore Rd.</u>   |   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b><br>STATE <u>Md.</u> COUNTY <u>Baltimore</u><br>CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>52 Catonsville</u><br>STREET ADDRESS (If rural, give location) <u>213 Westmore Rd.</u> |  |                                       |  |                  |  |        |      |       |      |
| <b>3. NAME OF DECEASED:</b><br>(Type or Print) <u>Mary E. Hudert</u>  |   | <b>4. DATE OF DEATH:</b><br>(Month) (Day) (Year) <u>7/18/55</u> <u>19</u>  |  |                                       |  |                  |  |        |      |       |      |
| <b>5. SEX:</b><br><u>Female</u>   | <b>6. COLOR OR RACE:</b><br><u>W.</u>   | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b><br><u>Widow</u>  | <b>8. DATE OF BIRTH:</b><br><u>Aug. 8, 1872</u> <u>82</u> yrs. <table border="1"> <tr> <td colspan="2">9. AGE last birthday: IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> | 9. AGE last birthday: IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |  | Months | Days | Hours | Min. |
| 9. AGE last birthday: IF UNDER 1 YEAR   |   | IF UNDER 24 HRS.   |  |                                       |  |                  |  |        |      |       |      |
| Months  | Days  | Hours  | Min.   |                                       |  |                  |  |        |      |       |      |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired): <u>H.W.</u>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY:</b><br><u>Queen Home</u>   |  |                                       |  |                  |  |        |      |       |      |
| <b>11. BIRTHPLACE</b> (State or foreign country): <u>Balto. Md.</u>   |   | <b>12. CITIZEN OF WHAT COUNTRY?</b>  |  |                                       |  |                  |  |        |      |       |      |
| <b>13. FATHER'S NAME:</b><br><u>Thuman</u>  |   | <b>14. MOTHER'S MAIDEN NAME:</b><br><u>Unknown</u>   |  |                                       |  |                  |  |        |      |       |      |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)  |   | <b>16. SOCIAL SECURITY No.:</b>  |  |                                       |  |                  |  |        |      |       |      |
| <b>17. INFORMANT &amp; ADDRESS:</b><br><u>Mrs. Dolores Popp 213 Westmore Rd.</u>  |   | <b>18. MEDICAL CERTIFICATION</b>   |  |                                       |  |                  |  |        |      |       |      |
| <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b><br><u>420.0</u><br>Immediate cause (a) <u>Arteriosclerotic Heart Disease</u><br>DUE TO<br>Antecedent cause(s) (b) <u>Arteriosclerosis, generalized</u><br>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>8 yrs.</u><br><u>unknown</u>  |  |                                       |  |                  |  |        |      |       |      |
| <b>II. OTHER SIGNIFICANT CONDITIONS:</b><br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |  |                                       |  |                  |  |        |      |       |      |
| <b>19a. DATE OF OPERATION:</b>  |   | <b>19b. MAJOR FINDINGS OF OPERATION:</b>   |  |                                       |  |                  |  |        |      |       |      |
| <b>20. AUTOPSY?</b><br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |  |  |                                       |  |                  |  |        |      |       |      |
| <b>21. ACCIDENT SUICIDE HOMICIDE</b> (Specify)  | <b>PLACE</b> (Home, farm, factory, street, OF office bldg., etc.)   | <b>(CITY OR TOWN)</b>  | <b>(COUNTY)</b>  |                                       |  |                  |  |        |      |       |      |
| <b>TIME</b> (Month) (Day) (Year) (Hour) OF INJURY   | <b>INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | <b>HOW DID INJURY OCCUR?</b>   |  |                                       |  |                  |  |        |      |       |      |
| <b>22. I hereby certify that I attended the deceased from</b> <u>July...1., 1947.,</u> <b>to</b> <u>July...18 19...55,</u> <b>that I last saw the deceased alive on</b> <u>Jan. 30, 1955.,</u> <b>and that death occurred at</b> <u>5:10 P.m.,</u> <b>from the causes and on the date stated above.</b><br><b>SIGNATURE</b> <u>[Signature]</u> <b>(DEGREE OR TITLE)</b> <u>M.D.</u> <b>ADDRESS</b> <u>1 Mallow Hill Ave., Baltimore, Md</u> <b>DATE SIGNED</b> <u>7/19/55</u> |   |  |  |                                       |  |                  |  |        |      |       |      |
| <b>23. BURIAL, CREMATION REMOVAL (Specify):</b><br><u>Burial</u>  | <b>DATE THEREOF</b><br><u>7/22/55</u>   | <b>NAME OF CEMETERY OR CREMATORY</b><br><u>Holy Cross</u>  | <b>LOCATION</b> (City, town, or county) (State)<br><u>A.A. Co. Md</u>  |                                       |  |                  |  |        |      |       |      |
| <b>DATE REC'D BY LOCAL REG.</b><br><u>7-21-55</u>   | <b>REGISTRAR'S SIGNATURE</b><br><u>[Signature]</u>  | <b>24. FUNERAL DIRECTOR</b><br><u>Harry H. Hutzler 4101 Edmondson Ave</u>  |  |                                       |  |                  |  |        |      |       |      |

06241



06342

## MARYLAND STATE DEPARTMENT OF HEALTH

Item 5, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

6345

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

|   |                           |   |                                      |
|---|---------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>COUNTY <u>Baltimore</u> MARYLAND   |                           | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Maryland</u> COUNTY                             |                                      |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Myrtle Beach, Middle River</u> LENGTH OF STAY (In this place) |                           | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Baltimore</u> |                                      |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Same</u>   |                           | STREET ADDRESS (If rural, give location) <u>924 Homestead St</u>                                  |                                      |
| 3. NAME OF DECEASED<br>(Type or Print) <u>HARVEY</u> (First) <u>Lytle</u> (Middle) <u>Hughes</u> (Last)   |                           | 4. DATE OF DEATH (Month) <u>7</u> (Day) <u>15</u> (Year) <u>1955</u>                              |                                      |
| 5. SEX <u>m</u>   | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)  | 8. DATE OF BIRTH <u>June 5, 1933</u> |
| 9. AGE last birthday <u>22</u> yrs.   |                           | 10. BIRTHPLACE (State or foreign country) <u>Baltimore</u>  |                                      |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mill worker</u>                                     |                           | 12. CITIZEN OF WHAT COUNTRY?  |                                      |
| 13. FATHER'S NAME <u>Harvey H. Hughes</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Anna M. Lytle</u>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                           | 16. SOCIAL SECURITY No. <u>212-30-7555</u>  |                                      |
| 17. INFORMANT AND ADDRESS <u>Lytle - aiken st.</u>  |                           |   |                                      |

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

850X  
Immediate cause

(a)

DROWNING -

## Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

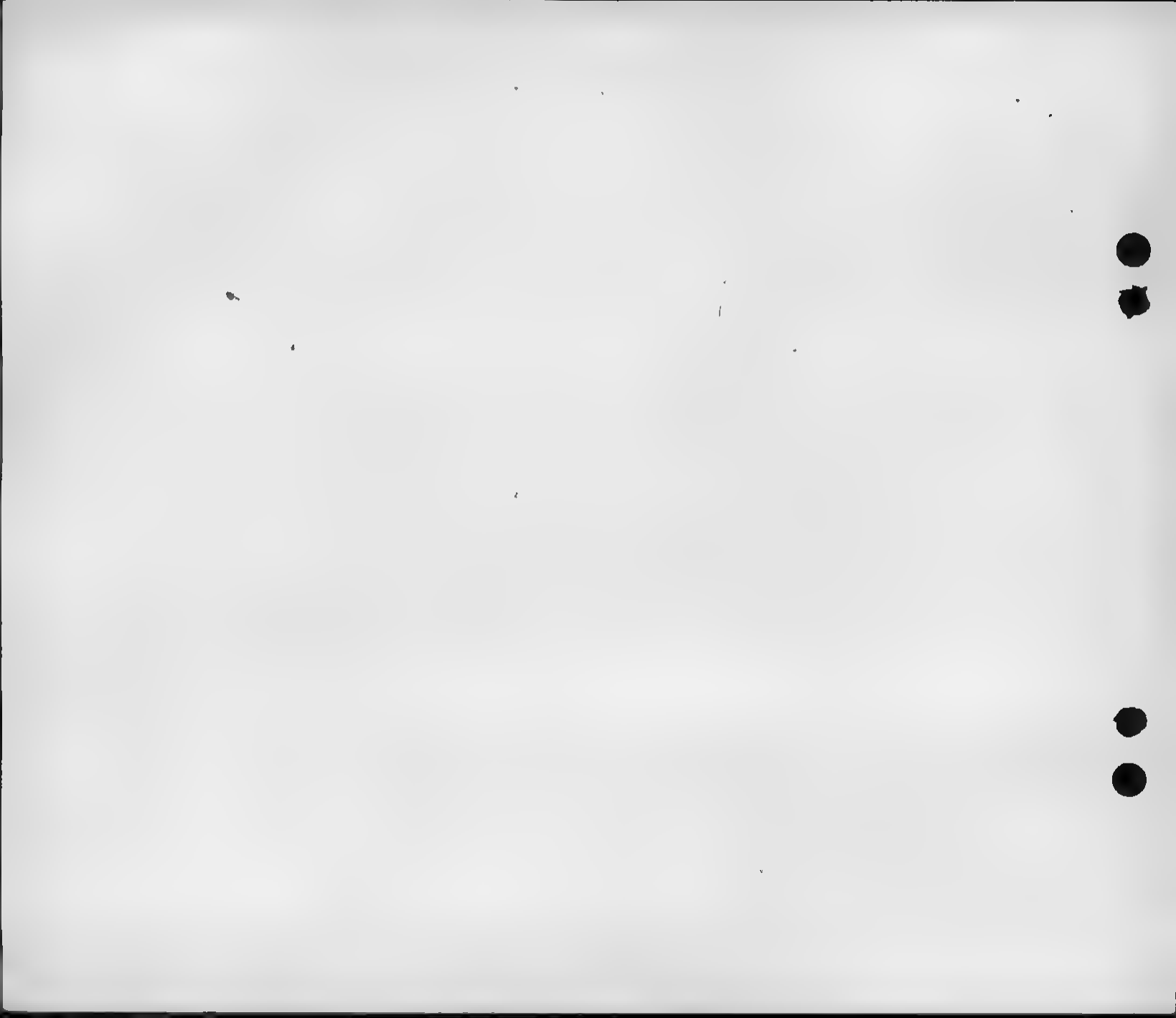
|   |   |
|---|---|
| 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | PLACE OF INJURY <u>Home</u> (CITY OR TOWN) <u>Middle River</u> (COUNTY) <u>Baltimore</u> (STATE) <u>Md</u>      |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-15-55</u> <u>12</u> m.                  | INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/> |
| HOW DID INJURY OCCUR? <u>Jumped from boat to rescue fuel</u>                            |   |

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, or Inquiry, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐

|  |   |
|--|---|
| SIGNATURE <u>J. B. Davis</u> (Degree or title) <u>MD</u> ADDRESS <u>Dep Med. Exam. - Dundas. 20th</u> DATE SIGNED <u>7/15/55</u> |   |
| 23. BURIAL, CREMATION, REMOVAL (Specify)   | DATE THEREOF <u>July 19, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Moulton Park</u> LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Md</u> |
| DATE REC'D BY LOCAL REG. <u>7/18/55</u> REGISTRAR'S SIGNATURE <u>H. A. Hedrick</u>   | 24. FUNERAL DIRECTOR <u>Wm Cook</u> ADDRESS <u>Inc - 1217 St Anne St</u>  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

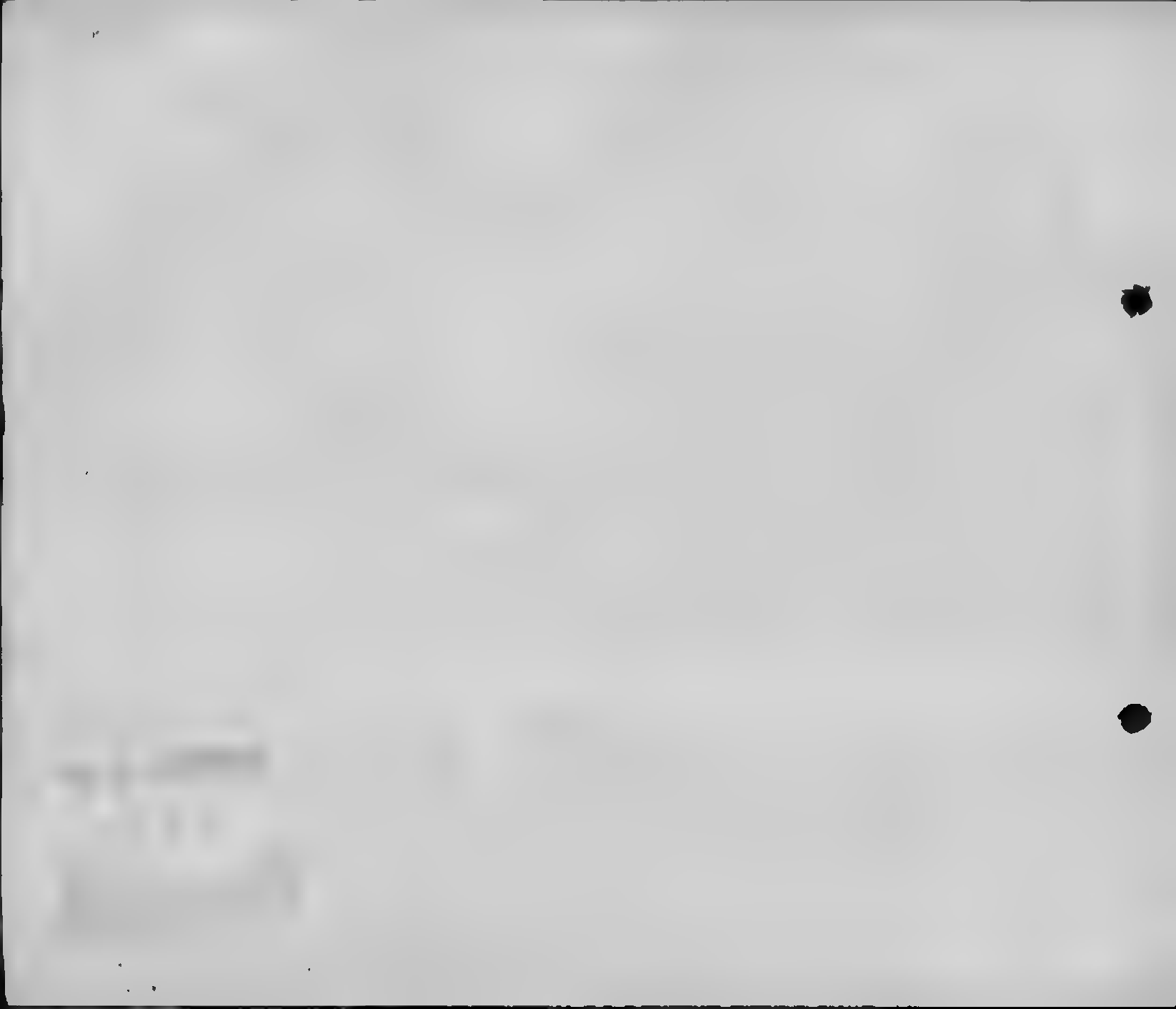
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06043

Reg. Dist.

No. 30

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH:   |  |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                               |  |  |  |
| COUNTY   |  | MARYLAND  |  | STATE  |  | COUNTY   |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   |  | LENGTH OF STAY (in this place)  |  | CITY (If outside corporate limits write RURAL and give nearest town) |  |  |  |
| 52 TOWN  |  |   |  | TOWN Baltimore 3401-4  |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |  |   |  | STREET ADDRESS (If rural, give location)                             |  |  |  |
| 14   |  |   |  | 7000 N. ...  |  |  |  |
| 3. NAME OF DECEASED:   |  |   |  | 4. DATE OF DEATH:  |  |  |  |
| (First)  |  | (Middle)  |  | (Last)   |  | (Month) (Day) (Year)   |  |
| (Type or Print)  |  |   |  |  |  | 19   |  |
| 5. SEX:  |  | 6. COLOR OR RACE:   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):                    |  | 8. DATE OF BIRTH:  |  |
|  |  |   |  |  |  | 7-2-55   |  |
| 9. AGE (last birthday):  |  | 10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):                          |  | 10b. KIND OF BUSINESS OR INDUSTRY:                                   |  | 11. BIRTHPLACE (State or foreign country):                                       |  |
| yrs. Months Days Hours Min.  |  |   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
|  |  |   |  |  |  |  |  |
| 13. FATHER'S NAME:   |  |   |  | 14. MOTHER'S MAIDEN NAME:  |  |  |  |
|  |  |   |  | Rachel ...   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY No.:   |  | 17. INFORMANT & ADDRESS:   |  |
| F-75   |  |   |  | Unknown  |  | Records Spring Grove State Hospital  |  |
| 18. MEDICAL CERTIFICATION  |  |   |  |  |  |  |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| Immediate cause (a) ...<br>DUE TO<br>Antecedent cause(s) (b) ...<br>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)   |  |   |  |  |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION:  |  |   |  | 19b. MAJOR FINDING OF OPERATION:                                     |  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
|  |  |   |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY  |  | 21c. (City or town) (County) (State)                                 |  | 21f. HOW DID INJURY OCCUR?   |  |
|  |  |   |  | Catonsville Baltimore Maryland                                       |  |  |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |  |  |  |  |  |
|  |  |   |  |  |  |  |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |  |  |  |  |  |
| SIGNATURE  |  | 1010 Leads on   |  | CHIEF MEDICAL EXAMINER   |  | DATE SIGNED  |  |
| George M. Kieffer  |  |   |  | DEPUTY MEDICAL EXAMINER  |  | 7-20-55  |  |
|  |  |   |  | M. D. ASSISTANT MEDICAL EXAM.  |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify):  |  | DATE THEREOF  |  | NAME OF CEMETERY OR CREMATORY  |  | LOCATION (City, town, or county) (State)   |  |
| Burial   |  | 7-28-55   |  | Spring Grove State Hospital  |  | Catonsville 28, Maryland   |  |
| DATE REC'D BY LOCAL REG.   |  | REGISTRAR'S SIGNATURE   |  | FUNERAL DIRECTOR   |  | ADDRESS  |  |
| 7-28-55  |  | T. E. Harry   |  | Spring Grove State Hospital  |  | Catonsville 28, Md.  |  |



6347

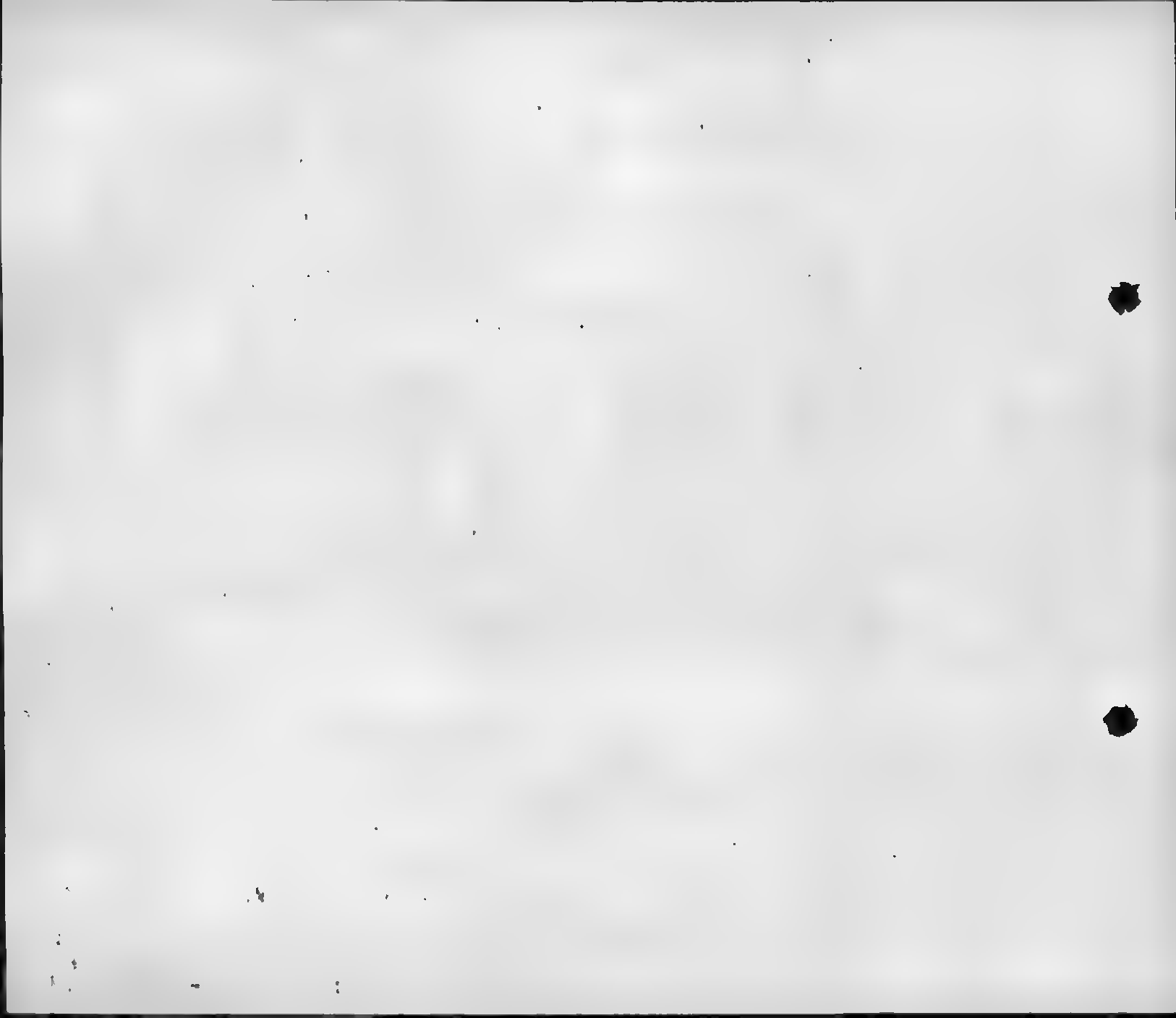
## CERTIFICATE OF DEATH

Reg. Dist. No. 4X

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH:   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |   |
| COUNTY <u>Baltimore 19</u>   | MARYLAND   | STATE <u>MD</u>   | COUNTY  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Sparrows Pt.</u>   | LENGTH OF STAY (in this place)   | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MD</u>                         |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7320 Hughes Ave.</u>  |  | STREET ADDRESS (If rural give location) <u>#1</u>   |   |
| 3. NAME OF DECEASED (Type or Print)  |  | 4. DATE (Month) (Day) (Year)  |   |
| (First) <u>Rosa</u> (Middle) <u>Jacobs</u> (Last)  |  | OF DEATH: <u>July 6</u> 19 <u>55</u>  |   |
| 5. SEX: <u>Female</u>  | 6. COLOR OR RACE: <u>white</u>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>  | 8. DATE OF BIRTH <u>May 16, 1874</u>                                |
| 9. AGE last birthday <u>81</u> yrs   |  | 10. IF UNDER 1 YEAR Months Days   | 11. IF UNDER 24 HRS Hours Min.                                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>   | 11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>    |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  | 13. FATHER'S NAME: <u>Wilson Hare</u>   |   |
| 14. MOTHER'S MAIDEN NAME: <u>Ellen Genter</u>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) |   |
| 16. SOCIAL SECURITY NO. <u>None</u>  |  | 17. INFORMANT & ADDRESS: <u>olin Jacobs - address as in #1</u>  |   |
| 18. MEDICAL CERTIFICATION  |  |   | INTERVAL BETWEEN ONSET AND DEATH                                    |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |   |   |
| IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>   |  |   | <u>24 hours</u>   |
| ANTECEDENT CAUSE (B) <u>Hypertensive Cardiovascular disease</u>  |  |   | <u>12 yrs</u>   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Uremia</u>  |  |   | <u>12 hours</u>   |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Epithelioma</u>  |  |   | <u>6 mo.</u>  |
| 19A. DATE OF OPERATION:  |  | 19B. MAJOR FINDINGS OF OPERATION  |   |
|  |  |   |   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   | 21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <u>3/8/1949</u> to <u>7/6/1955</u> that I last saw the deceased alive on <u>7/6/1955</u> and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above. |  |   |   |
| SIGNATURE <u>Rosa H. Tallen, M.D.</u>  |  | ADDRESS <u>6908 North P+ Rd Balto 19</u>  | DATE SIGNED <u>7/6/55</u>   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   | DATE THEREOF <u>7/9/55</u>   | NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>   | LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| DATE REC'D BY LOCAL REGISTRAR <u>7-7-55</u>  | REGISTRAR'S SIGNATURE <u>C</u>   | 24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>  | ADDRESS <u>1217 E. Paul St.</u>                                     |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





6348

## CERTIFICATE OF DEATH

Reg. Dist. No.

## I. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town)

X TOWN Cockeysville(in this place)  
lyr.HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSMt. Royal Ave.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MarylandCOUNTY Harford

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN AberdeenSTREET  
ADDRESS

(If rural give location)

Swannsberry3. NAME OF  
DECEASED:  
(Type or Print)

(First)

Annie

(Middle)

D.

(Last)

Jay4. DATE  
OF  
DEATH:

(Month)

(Day)

(Year)

July 29, 1955

## 5. SEX:

Female6. COLOR OR  
RACE:White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):widowed

## 8. DATE OF BIRTH:

Feb. 20,1863

## 9. AGE last birthday: IF UNDER 1 YEAR

IF UNDER 24 HRS.

yrs.

Months

Days

Hours

Min.

9210a. USUAL OCCUPATION Give kind of  
work done during most of working life,  
even if retired):Housewife10b. KIND OF BUSINESS  
INDUSTRY:None

## 11. PLACE (State or foreign country):

Maryland12. CITIZEN OF WHAT  
COUNTRY?U. S.

## 13. FATHER'S NAME:

S. Griffith Davis

## 14. MOTHER'S MAIDEN NAME:

Ann Hollister15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)No

## 16. SOCIAL SECURITY No.:

None

## 17. INFORMANT &amp; ADDRESS:

Mrs. J. Merryman Black Cockeysville, Maryland

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170X  
Immediate cause(a) Carcinoma of the right breast  
DUE TO

## Antecedent causes (s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.(b) DUE TO

(c)

Interval Between  
Onset And Death5 yrs.

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Not While  
Work ☐ At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/28/43, 1919, to 7/29/55, 1955, that I last saw the deceasedalive on 7/29/55, 1955, and that death occurred at 8:50 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Doris B. JonesM.D. 11 East Chase St., City-2.7/30/55.

## 23. BURIAL, CREMATION, REMOVAL (Specify)

Entombment

DATE THEREOF

July 31, 1955

NAME OF CEMETERY OR CREMATORY

Spesutia Cemetery

LOCATION (City, town, or county)

Perryman, Harford Co., MarylandDATE REC'D BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

John O. Mitchell & Sons Inc. 1900 Eutaw Place

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1000 R. 5

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

6349

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH-<br>COUNTY Baltimore   |  | MARYLAND   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE Maryland  |  | COUNTY 1   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN Edgemere |  | LENGTH OF STAY<br>(in this place)                                    |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN Edgemere                      |  | X  |  |
| HOSPITAL OR<br>INSTITUTION OR<br>STREET ADDRESS 2607 Manor Avenue                      |  |  |  | STREET<br>ADDRESS 2607 Manor Avenue   |  | (If rural, give location)<br>1                   |  |
| 3. NAME OF<br>DECEASED<br>(Type or Print) Adelaide                                     |  | (First)  |  | (Middle) V.   |  | (Last) Johnson                                   |  |
| 4. DATE<br>OF<br>DEATH July  |  | (Month)  |  | (Day) 11  |  | (Year) 1955                                      |  |
| 5. SEX<br>Female   |  | 6. COLOR OR RACE<br>White  |  | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED,<br>(Specify) Widow  |  | 8. DATE OF BIRTH<br>May 20, 1870                 |  |
| 9. AGE last birthday<br>85 yrs.  |  | If under 1 year<br>Months Days Hours Min.                            |  | 10a. USUAL OCCUPATION (Give kind of work<br>done during most of working life, even if retired)<br>Housewife |  | 10b. KIND OF BUSINESS OR<br>INDUSTRY<br>Own Home |  |
| 11. BIRTHPLACE (State or foreign country)<br>Baltimore                                 |  | 12. CITIZEN OF WHAT<br>COUNTRY?                                      |  | 13. FATHER'S NAME<br>William C. Rogers  |  | 14. MOTHER'S MAIDEN NAME<br>Mary Bourbein        |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)                   |  | 16. SOCIAL SECURITY No.<br>(If yes, give war or dates of<br>service) |  | 17. INFORMANT AND ADDRESS<br>Mrs Mamie Miller 2607 Manor Avenue   |  |  |  |

### 18. MEDICAL CERTIFICATION

|  |  |                                     |
|--|--|-------------------------------------|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                          |  | INTERVAL BETWEEN<br>ONSET AND DEATH |
| 44-5X Immediate cause (a) Acute Pulmonary Edema                              |  |                                     |
| Antecedent cause(s) (b) Hypertensive Arteriosclerotic Cardiovascular Disease |  |                                     |
| (c)  |  |                                     |

|  |  |
|--|--|
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not<br>related to the disease or condition causing death. |  |
|--|--|

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19a. DATE OF OPERATION                        |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 21. ACCIDENT<br>SUICIDE<br>HOMICIDE           |  | (Specify) PLACE (Home, farm, factory, street,<br>OF office bldg., etc.) INJURY                          |  | (CITY OR TOWN) (COUNTY) (STATE)   |  |
| TIME (Month) (Day) (Year) (Hour)<br>OF INJURY |  | INJURY OCCURRED<br>While at Work <input type="checkbox"/> Not While<br>At work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from July 10, 1955, to July 11, 1955, that I last saw the deceased alive on July 11, 1955, and that death occurred at 4:45 p.m., from the causes and on the date stated above.

SIGNATURE David Owens, M.D. ADDRESS 914 D Street Baltimore 19 Md. DATE SIGNED 7/13/55

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 23. BURIAL, CREMATION<br>REMOVAL (Specify) Burial |  | DATE THEREOF July 15, 1955               |  | NAME OF CEMETERY OR CREMATORY Oak Lawn                        |  | LOCATION (City, town, or county) Baltimore, Maryland |  |
| DATE REC'D BY LOCAL<br>SEC July 13-55             |  | REGISTRAR'S SIGNATURE Lawrence J. Harber |  | 24. FUNERAL DIRECTOR<br>Lilly & Zeiler Inc., 403 S. Wolfe St. |  | ADDRESS  |  |

MARGIN RESERVED FOR BINDING

VS. A13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1965

1965

1965

## 6250 CERTIFICATE OF DEATH

Reg. Dist. No. 44

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH   |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                 |  |
| COUNTY <u>Baltimore</u> MARYLAND  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MIDDLE RIVER</u> | STATE <u>MD</u> COUNTY <u>BALTO</u>                                    | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ROSS EX</u> |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>19 Harrison Ave</u>  |   | STREET ADDRESS (If rural give location) <u>58 RIVERSIDE RD.</u>        |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |   | 4. DATE (Month) (Day) (Year)   |  |
| <u>BESSIE</u> <u>JOHNSTON</u>   |   | OF DEATH: <u>7</u> <u>19</u> <u>1955</u>                               |  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u>   | 7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>M</u>             | 8. DATE OF BIRTH: <u>11/27/03</u>  |
| 9. AGE last birthday <u>51</u> yrs  |   | 10. IF UNDER 1 YEAR Months Days Hours Min.                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>   |   | 10B. KIND OF BUSINESS OR INDUSTRY: <u>VA.</u>                          |  |
| 11. BIRTHPLACE (State or foreign country): <u>VA.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME: <u>?</u>   |   | 14. MOTHER'S MAIDEN NAME: <u>?</u>                                     |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT & ADDRESS: <u>CLARENCE L JOHNSTON</u>   |   |  |  |
| 18. MEDICAL CERTIFICATION   |   | INTERVAL BETWEEN ONSET AND DEATH                                       |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |   |  |  |
| 345X IMMEDIATE CAUSE (A) <u>Disseminate of sclerosis spinal cord</u>  |   | 5 years  |  |
| ANTECEDENT CAUSE (B) <u>Trophic ulcer body</u>  |   | 1 year   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)   |   |  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |   |  |  |
| 19A. DATE OF OPERATION:   |   | 19B. MAJOR FINDINGS OF OPERATION                                       |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) |  |
| 21C. WHERE DID (City or town) (County) (State)  |   | 21D. TIME (Month) (Day) (Year) (Hour)                                  |  |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <u>Sept. 19, 1955</u> , to <u>July 12, 1955</u> , that I last saw the deceased alive on <u>July 19, 1955</u> , and that death occurred at <u>34 M.</u> from the causes and on the date stated above. |   |  |  |
| SIGNATURE <u>A. L. Koleschewski</u>   |   | DATE SIGNED <u>M. D. 1825 Eastern Blvd. Balto. 21, Md 7/19/55</u>      |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>  |   | DATE THEREOF <u>7/21/55</u>  |  |
| NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>   |   | LOCATION (City, town, or county) <u>BALTO. CO. MD.</u>                 |  |
| DATE REC'D BY LOCAL REGISTRAR <u>7/20/55</u>  |   | REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>                             |  |
| 24. FUNERAL DIRECTOR <u>J. Gordon Connolly</u>  |   | ADDRESS <u>Emory Rd</u>  |  |

MARGIN RESERVED FOR HANDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 12

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH:   |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |
| COUNTY <b>Baltimore</b>  | MARYLAND  | STATE <b>Maryland</b>  | COUNTY   |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br><b>TOWN Catonsville</b>  | LENGTH OF STAY (in this place)  | CITY (If outside corporate limits write RURAL and give nearest town)<br><b>OR TOWN Baltimore</b>   | <b>X</b>   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>Catonsville Nursing Home<br/>315 Ingleside Avenue</b>  |   | STREET ADDRESS (If rural, give location)<br><b>5215 Garmouth Road</b>  | <b>1</b>   |
| 3. NAME OF DECEASED:<br>(Type or Print)  | (First)   | (Middle)   | (Last)   |
| <b>RALPH</b>   | <b>P.</b>   | <b>JOHNSTON</b>  |  |
| 5. SEX:<br><b>male</b>   | 6. COLOR OR RACE:<br><b>white</b>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED.<br>(Specify): <b>Widowed</b>  | 8. DATE OF BIRTH:<br><b>October 30, 1875</b>                           |
| 9. AGE last birthday:<br><b>79</b> yrs.  |   | 4. DATE OF DEATH<br><b>July 2, 1955</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Harness Maker</b>   | 10b. KIND OF BUSINESS OR INDUSTRY:  | 11. BIRTHPLACE (State or foreign country):<br><b>Ohio</b>  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                        |
| 13. FATHER'S NAME:<br><b>George L. Johnston</b>  |   | 14. MOTHER'S MAIDEN NAME:<br><b>Martha Hayes</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unk.)<br><b>no</b>   | 16. SOCIAL SECURITY No.:  | 17. INFORMANT & ADDRESS:<br><b>Mrs. M. Ethel Plum, 5215 Garmouth Road</b>  |  |
| 18. MEDICAL CERTIFICATION  |   |  |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |   |  | INTERVAL BETWEEN ONSET AND DEATH                                       |
| 42. Immediate cause (a) <b>Arteriosclerotic Heart Disease</b>  |   |  | <b>unknown</b>   |
| Antecedent cause(s) (b) <b>Generalized Arteriosclerosis</b>  |   |  | <b>unknown</b>   |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)   |   |  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Fracture, right hip</b>   |   |  | <b>8 days</b>  |
| 19a. DATE OF OPERATION:<br><b>no</b>   | 19b. MAJOR FINDING OF OPERATION:<br><b>none</b>   | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   | 21b. PLACE (Home, farm, factory, street, office bldg., etc.)<br><b>Nursing Home Catonsville, Balto. Co., Md.</b>  | 21c. (City or town) (County) (State)   |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>6-24-55 11 AM.</b>   | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br><b>Fell off bed</b>  |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |  |  |
| SIGNATURE<br><b>W. L. Caples</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED<br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <b>7-2-55</b> |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify):<br><b>burial</b>   | DATE THEREOF<br><b>7/5/55</b>   | NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park Cemetery</b>  | LOCATION (City, town, or county) (State)<br><b>Parkville, Maryland</b> |
| DATE REC'D BY LOCAL REG.<br><b>5</b>   | REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   | 24. FUNERAL DIRECTOR<br><b>Wm. Cook, Inc.</b> 1217 St. Paul Street   |  |





6352

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH

COUNTY **BALTIMORE**

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN **FORT HOWARD,**

MARYLAND

LENGTH OF STAY (in this place)

**4 DAYS**

HOSPITAL OR INSTITUTION OR

57 STREET ADDRESS **VETERANS ADMINISTRATION HOSPITAL**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MARYLAND** COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN **BALTIMORE**

STREET ADDRESS

(If rural give location)

**1707 E. LANVALE STREET**

## 3. NAME OF DECEASED (Type or Print)

(First)

(Middle)

(Last)

MALE

SEX

COLOR

COLORED

BEN

(NMI)

JONES

MALE

SEX

COLOR

COLORED

SINGLE

MARRIED

WIDOWED

DIVORCED

(Specify):

MARRIED

## 8. DATE OF BIRTH:

**6-25-95**

## 4. DATE (Month)

(Day)

(Year)

OF

DEATH:

**JULY****10****1955**

## 9. AGE last birthday

IF UNDER 1 YEAR

Months

Days

Hours

Min.

**60 yrs**

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)

**CEMENT FINISHER CONTRACTING CO.**

## 10B. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country):

**FAIRFIELD CO., SOUTH CAROLINA U.S.A**

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME

**BOYD JONES**

## 14. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unk.) (If Yes, give war or dates of service)

**YES****WW I**

## 15. SOCIAL SECURITY NO.

**578-16-1537**

## 17. INFORMANT'S ADDRESS:

**CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.**

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**331X**

IMMEDIATE CAUSE

(A)

**CEREBRAL HEMORRHAGE**

DUE TO

ANTECEDENT CAUSE (B):

(B)

**GENERALIZED ARTERIOSCLEROSIS**

DUE TO

DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

## INTERVAL BETWEEN ONSET AND DEATH

**4 DAYS****UNKNOWN**

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐NO ☒

## 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)

## 21C. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that **VA** attended the deceased from **JULY 6, 1955**, to **JULY 10, 1955**, the date of death occurred on **JULY 10, 1955**, and that death occurred at **4:30 PM**, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

**FRANCIS G. DICKEY, CHIEF, MEDICAL SERVICE, VAH FT. HOWARD, MD****7/12/55**

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

**BURIAL****BALTIMORE NATIONAL****BALTIMORE, MARYLAND**

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

**ELROY O WILSON****2004 Orleans St.****Baltimore, Md**

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1911

Dec 1

6353

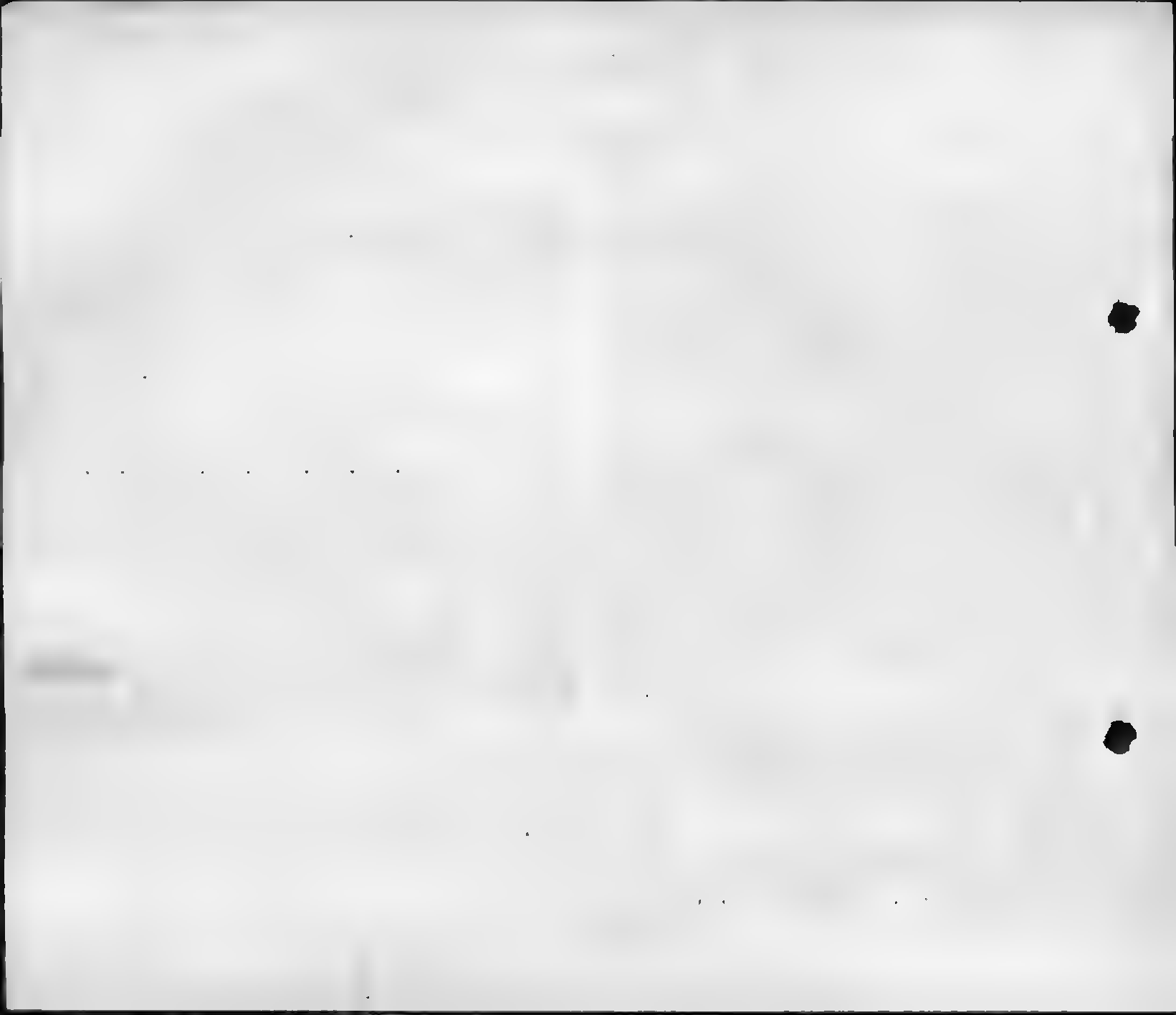
CERTIFICATE OF DEATH

Reg. Dist. No. 4

|   |   |  |                                     |
|---|---|--|-------------------------------------|
| 1 PLACE OF DEATH  |   | 2 USUAL RESIDENCE (HOME) OF DECEASED:  |                                     |
| COUNTY <b>BALTIMORE</b>   | MARYLAND  | STATE <b>MARYLAND</b>  | COUNTY                              |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <b>FORT HOWARD</b>  | LENGTH OF STAY (In this place)<br><b>107 DAYS</b> | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <b>BALTIMORE</b> | <b>301-4</b>                        |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |   | STREET ADDRESS (If rural give location)<br><b>302 E. LANVALE STREET</b>                              |                                     |
| 3. NAME OF DECEASED (Type or Print)<br><b>CLARENCE JONES</b>  |   | 4. DATE (Month) (Day) (Year)<br><b>JULY 27 1955</b>  |                                     |
| 5 SEX<br><b>MALE</b>  | 6 COLOR OR RACE<br><b>COLORED</b>                 | 7. SINGLE, MARRIED, WIDDED, DIVORCED, (Specify)<br><b>MARRIED</b>                                    | 8. DATE OF BIRTH<br><b>12-28-98</b> |
| 10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CHAUFFEUR</b>  |   | 10B KIND OF BUSINESS OR INDUSTRY<br><b>TRUCK COMPANY</b>   |                                     |
| 11 BIRTHPLACE (State or foreign country)<br><b>RICHMOND, VIRGINIA</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                     |
| 13 FATHER'S NAME<br><b>ANDREW JONES</b>   |   | 14 MOTHER'S MAIDEN NAME<br><b>LUCY CLAIBORNE</b>   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)<br><b>YES WW I</b>  |   | 16. SOCIAL SECURITY NO.<br><b>217-16-6545</b>  |                                     |
| 17 INFORMANT'S ADDRESS<br><b>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</b>  |   |  |                                     |
| 18. MEDICAL CERTIFICATION   |   | INTERVAL BETWEEN ONSET AND DEATH   |                                     |
| 1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><b>241X IMMEDIATE CAUSE</b><br><b>ASTHMA</b><br><b>ANTECEDENT CAUSE (S)</b><br><b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>   |   | <b>10 MINUTES</b>  |                                     |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.<br><b>CONVALESCENCE FROM BURNS</b>   |   | <b>3 1/2 MONTHS</b>  |                                     |
| 19A. DATE OF OPERATION:<br><b>7-25-55</b>   |   | 19B. MAJOR FINDINGS OF OPERATION<br><b>Skin Graft to right axilla</b>                                |                                     |
| 20. AUTOPSY?<br><b>YES</b>  |   |  |                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER)<br><b>NO</b>  |   | 21B. PLACE (Home, farm, factory) OF INJURY street, office bldg., etc.<br><b>VA</b>                   |                                     |
| 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)<br><b>BALTIMORE</b>  |   |  |                                     |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>APR. 11, 1955, 8:57AM</b>   |   | 21E. INJURY OCCURRED While at work Not while at work<br><b>While at work</b>                         |                                     |
| 21F. HOW DID INJURY OCCUR?<br><b>VA</b>   |   |  |                                     |
| 22. I hereby certify that <b>CLARENCE JONES</b> attended the deceased from <b>APR. 11, 1955</b> , to <b>JULY 27, 1955</b> , and that death occurred at <b>8:57AM</b> , from the causes and on the date stated above.<br><b>WILLIAM B. VANDEGRIFT, M.D.</b> ADDRESS <b>M. D. VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>7-28-55</b> |   |  |                                     |
| 23 BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |   | DATE THEREOF<br><b>8/1/55</b>  |                                     |
| NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL CEMETERY</b>   |   | LOCATION (C. t., town, or county) (State)<br><b>BALTIMORE, MARYLAND</b>                              |                                     |
| DATE REC'D BY LOCAL REGISTRAR<br><b>8/1/55</b>  |   | REGISTRAR'S SIGNATURE<br><b>CHARLES R. LAW MORTUARY</b>  |                                     |
| 24. FUNERAL DIRECTOR<br><b>CHARLES R. LAW MORTUARY</b>  |   | ADDRESS<br><b>802-04 MADISON AVE. BALTIMORE 1, MARYLAND</b>  |                                     |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6354

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) Towson LENGTH OF STAY (in this place) 7 daysHOSPITAL OR INSTITUTION OR STREET ADDRESS THE SHEPPARD & ENOCH PRATT HOSPITAL

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTYCITY (If outside corporate limits, write RURAL and give nearest town) Baltimore OR TOWN 2801 4STREET ADDRESS (If rural give location) 320 W. University Pkwy.

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Walter Holiday Jones, Sr.

4. DATE OF DEATH:

Month

(Day)

(Year)

(Type or Print)

July 41955

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

yrs.

Months

Days

Hours

Min.

MaleWhiteMarried Jan 1, 19738282828282

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

No.No.Hospital Records.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1  
Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Chronic myocarditisGeneralized arteriosclerosis

Interval Between Onset And Death

Unk11

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Chronic Brain Syndrome - Papez3 Wks +

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 28, 1955, to July 4, 1955, that I last saw the deceasedalive on July 2, 1955, and that death occurred at 1 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

Burial7/7/55Druid Ridge Cem.Pikesville, Md.Md.6-55Wm. J. Fickens, SonsWm. J. Fickens, SonsBaltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6253

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06252

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH:  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |
| COUNTY <u>Baltimore</u> MARYLAND  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>   | STATE <u>Maryland</u> COUNTY <u>Baltimore</u>                                    | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dundalk</u> |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2600 Ambler Rd.</u>  | STREET ADDRESS <u>2600 Ambler Rd.</u>  |  |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |  | 4. DATE (Month) (Day) (Year)   |  |
| <u>John Andrew Kay</u>  |  | DATE OF DEATH: <u>July 20</u> 19 <u>55</u>                                       |  |
| 5. SEX: <u>Male</u>   | 6. COLOR OR RACE: <u>White</u>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Widowed</u>                            | 8. DATE OF BIRTH: <u>Dec. 7, 1937</u>  |
| 9. AGE last birthday <u>67</u> yrs.   |  | 10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                       |  |
| 11. BIRTHPLACE (State or foreign country): <u>Detroit Mich.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                       |  |
| 13. FATHER'S NAME: <u>???</u> <u>Kay</u>  |  | 14. MOTHER'S MAIDEN NAME: <u>Sarah Watson</u>                                    |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>---</u>  |  | 16. SOCIAL SECURITY NO. <u>none</u>  |  |
| 17. INFORMANT & ADDRESS: <u>Mrs Mary N. Black 2600 Ambler Rd.</u>   |  |  |  |
| 18. MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |
| IMMEDIATE CAUSE (A) <u>420.1</u> <u>Coronary Occlusion</u>  |  | <u>1 hour</u>  |  |
| ANTECEDENT CAUSE (B) <u>Coronary Atherosclerosis</u>  |  | <u>5 years</u>   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |  |
| 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   | 21C. WHERE DID (City or town) (County) (State)                                   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <u>7/11</u> , 19 <u>55</u> to <u>7/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/14</u> , 19 <u>55</u> , and that death occurred at <u>2:00</u> A.M., from the causes and on the date stated above. |  |  |  |
| SIGNATURE <u>John T. Everett</u> M.D. 3501 Fair Ave.  |  | DATE SIGNED <u>7/20/55</u>   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  | DATE THEREOF <u>7/25/55</u>  | NAME OF CEMETERY OR CREMATORY <u>Colfax Cem.</u>                                 | LOCATION (City, town, or county) (State) <u>Bad Axe Mich.</u>                                |
| DATE REC'D BY LOCAL REGISTRAR   | REGISTRAR'S SIGNATURE <u>John A. Moran</u>   | 24. FUNERAL DIRECTOR ADDRESS <u>3000 E. Balto. St.</u>                           |  |





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6355

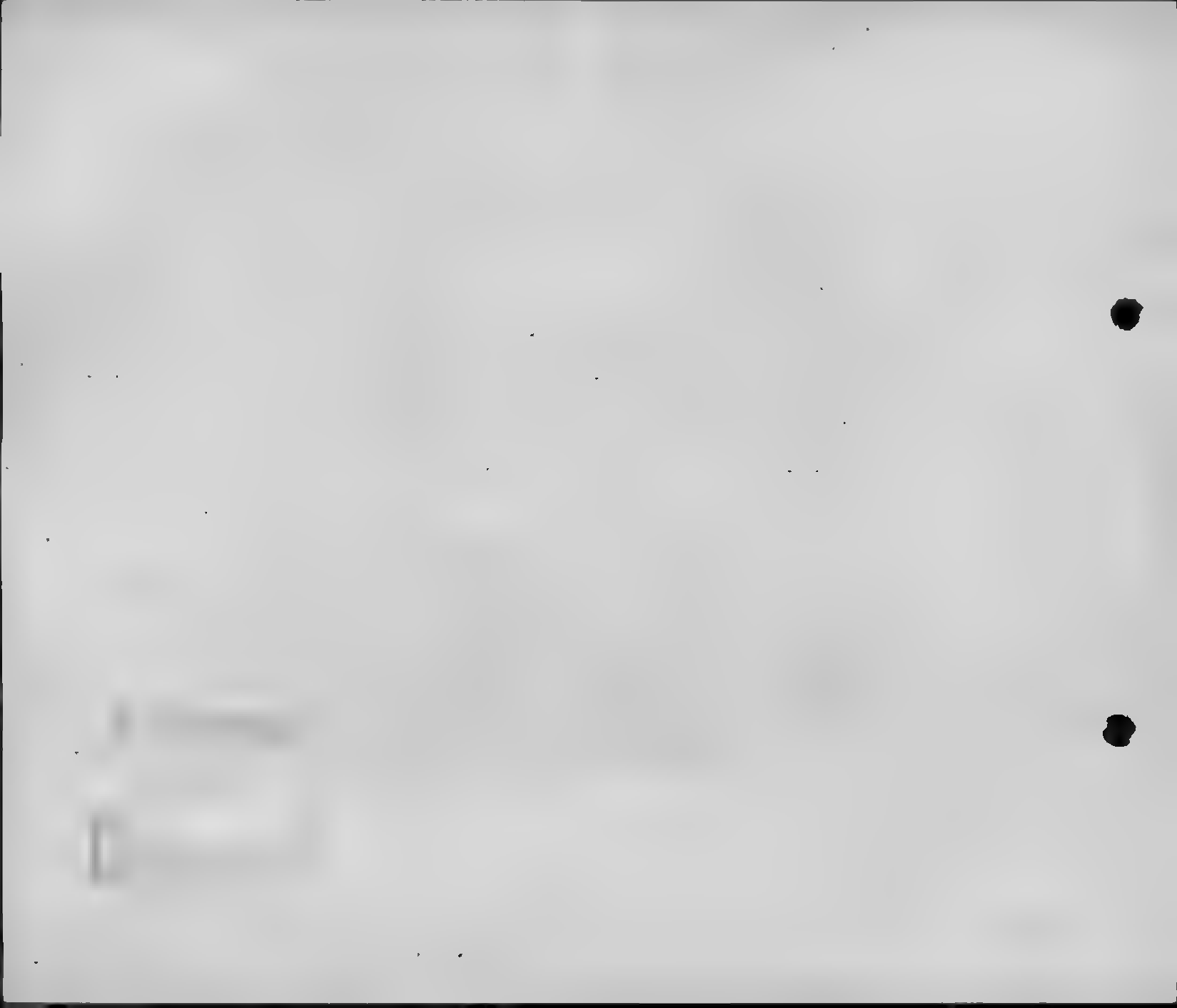
06353

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 33

|  |                   |   |                      |  |                                  |  |                                  |
|--|-------------------|---|----------------------|--|----------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH:   |                   |   |                      | 2. USUAL RESIDENCE (HOME) OF DECEASED:                               |                                  |  |                                  |
| COUNTY <b>Baltimore</b>  |                   | MARYLAND  |                      | STATE <b>Maryland</b>  |                                  | COUNTY <b>Baltimore</b>                  |                                  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   |                   | LENGTH OF STAY (In this place)  |                      | CITY (If outside corporate limits write RURAL and give nearest town) |                                  | OR TOWN                                  |                                  |
| <input checked="" type="checkbox"/> TOWN <b>Owings Mills</b>   |                   |   |                      | TOWN <b>Owings Mills,</b>  |                                  |  |                                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                   | <b>Dolfield Road</b>  |                      | STREET ADDRESS (If rural, give location)                             |                                  | <b>Dolfield Road</b>                     |                                  |
| 3. NAME OF DECEASED:   |                   | (First) (Middle) (Last)   |                      | 4. DATE OF DEATH   |                                  | (Month) (Day) (Year)                     |                                  |
| (Type or Print)  |                   | <b>J. Delano Kegan</b>  |                      | <b>July 1,</b>   |                                  | <b>19 55</b>                             |                                  |
| 5. SEX:  | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)  | 8. DATE OF BIRTH:    | 9. AGE last birthday:  | IF UNDER 1 YEAR IF UNDER 24 HRS. |  |                                  |
| <b>Male</b>  | <b>White</b>      | <b>Married</b>  | <b>Aug. 28, 1913</b> | <b>41</b>  | Months                           | Days                                     | Hours Min.                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):  |                   | 10b. KIND OF BUSINESS OR INDUSTRY:  |                      | 11. BIRTHPLACE (State or foreign country):                           |                                  | 12. CITIZEN OF WHAT COUNTRY?             |                                  |
| <b>Bay Piolet, Assn., Md. Piolets</b>  |                   | <b>Maryland</b>   |                      | <b>U.S.</b>  |                                  |  |                                  |
| 13. FATHER'S NAME:   |                   |   |                      | 14. MOTHER'S MAIDEN NAME:  |                                  |  |                                  |
| <b>Milton B. Kegan</b>   |                   |   |                      | <b>Regina Delano</b>   |                                  |  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk/ (If Yes, give war or dates of service)   |                   | 16. SOCIAL SECURITY No.:  |                      | 17. INFORMANT & ADDRESS:   |                                  |  |                                  |
| <b>Yes</b> <b>W.W.2</b>  |                   |   |                      | <b>Mrs. Tjark Susemihl - Owings Mills, Md.</b>                       |                                  |  |                                  |
| 18. MEDICAL CERTIFICATION  |                   |   |                      |  |                                  |  | INTERVAL BETWEEN ONSET AND DEATH |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |                   |   |                      |  |                                  |  |                                  |
| Immediate cause (a) ... <b>Shot through head with a bullet (Suicide)</b>   |                   |   |                      |  |                                  |  | <b>5 min.</b>                    |
| DUE TO   |                   |   |                      |  |                                  |  |                                  |
| Antecedent cause(s) (b) ... <b>Depression, alcoholism &amp; marital difficulties,</b>  |                   |   |                      |  |                                  |  | <b>6 months</b>                  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause DUE TO  |                   |   |                      |  |                                  |  |                                  |
| stating underlying cause last (c)  |                   |   |                      |  |                                  |  |                                  |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>None</b>  |                   |   |                      |  |                                  |  |                                  |
| 19a. DATE OF OPERATION:  |                   |   |                      | 19b. MAJOR FINDING OF OPERATION:                                     |                                  |  |                                  |
| <b>None</b>  |                   |   |                      | <b>None</b>  |                                  |  |                                  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                   | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <b>Home</b>                                |                      | 21c. (City or town) (County) (State)                                 |                                  |  |                                  |
| <b>Owings Mills, Baltimore Md.</b>   |                   |   |                      |  |                                  |  |                                  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>July 1, 55 12:05 P.M.</b>   |                   | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |                      | 21f. HOW DID INJURY OCCUR? <b>Shot himself</b>                       |                                  |  |                                  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                   |   |                      |  |                                  |  |                                  |
| SIGNATURE  |                   | CHIEF MEDICAL EXAMINER  |                      | DEPUTY MEDICAL EXAMINER  |                                  | DATE SIGNED                              |                                  |
| <b>D. D. Taylor</b>  |                   |   |                      |  |                                  | <b>7/8/55</b>                            |                                  |
| 23. BURIAL, CREMATION, REMOVAL (Specify):  |                   | DATE THEREOF  |                      | NAME OF CEMETERY OR CREMATORY  |                                  | LOCATION (City, town, or county) (State) |                                  |
| <b>Burial</b>  |                   | <b>July 5, 1955</b>   |                      | <b>Woodlawn</b>  |                                  | <b>Baltimore County</b>                  |                                  |
| DATE REC'D BY LOCAL REG.   |                   | REGISTRAR'S SIGNATURE   |                      | 24. FUNERAL DIRECTOR   |                                  | ADDRESS                                  |                                  |
| <b>7-1-55</b>  |                   | <b>Mary B. E. Line</b>  |                      | <b>Wm. J. Tickner &amp; Sons, Baltimore, Md.</b>                     |                                  |  |                                  |



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06354

6356

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH:   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |   |
| COUNTY <i>Baltimore</i>  | MARYLAND   | STATE <i>Md.</i>   | COUNTY <i>Baltimore</i>                 |
| CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <i>X</i><br><i>Seboville</i>   | LENGTH OF STAY (in this place)                           | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>X</i><br><i>Seboville</i>   |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Clays Lane, R.F.D. 5</i>  |  | STREET ADDRESS (If rural give location) <i>Clays Lane, R.F.D. 5 Box 237-7</i>  |   |
| 3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last)<br><i>Hugo August Kelbel</i>  | 4. DATE (Month) (Day) (Year)<br>OF DEATH: <i>7/12/55</i> |  |   |
| 5. SEX: <i>M.</i>  | 6. COLOR OR RACE: <i>W.</i>                              | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH: <i>April 25, 1894</i> |
| 9. AGE last birthday: <i>61</i> yrs.   |  | 10. UNDER 1 YEAR: Months Days Hours Min.   | 11. UNDER 24 HRS.                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baker</i>   |  | 10B. KIND OF BUSINESS OR INDUSTRY: <i>Seidelbach Co.</i>   |   |
| 11. BIRTHPLACE (State or foreign country): <i>Germany</i>  |  | 12. CITIZEN OF WHAT COUNTRY: <i>W.S.A.</i>   |   |
| 13. FATHER'S NAME: <i>Kelbel</i>   |  | 14. MOTHER'S MAIDEN NAME: <i>Unknown</i>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO: <i>219-34-1501</i>   |   |
| 17. INFORMANT & ADDRESS: <i>Mrs. Anna Kelbel, Clays Lane, Balto. 7, Md.</i>  |  | 18. MEDICAL CERTIFICATION  |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| IMMEDIATE CAUSE: <i>H2O1</i>   |  | ?  |   |
| ANTECEDENT CAUSE (S):  |  | 3+ yrs   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |  | (A) <i>Marie Cormany Occlusi</i>   |   |
| (B) <i>H.T.C.V.D.</i>  |  | (C) <i>Ant. Sclerous</i>   |   |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH   |  |  |   |
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.)  |   |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?   |  |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 21F. HOW DID INJURY OCCUR?   |  |  |   |
| 22. I hereby certify that I attended the deceased from <i>7/9/55</i> , 19 <i>55</i> , to <i>7/12</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>7/11</i> , 19 <i>55</i> , and that death occurred at <i>1:15 PM</i> , from the causes and on the date stated above. |  |  |   |
| SIGNATURE: <i>[Signature]</i>  |  | DATE SIGNED  |   |
| 23. BURIAL, CREMATION, REMOVAL, (SPECIFY)  |  | DATE THEREOF   |   |
| 23. BURIAL, CREMATION, REMOVAL, (SPECIFY)  |  | NAME OF CEMETERY OR CREMATORY  |   |
| 23. BURIAL, CREMATION, REMOVAL, (SPECIFY)  |  | LOCATION (City, town, or county) (State)   |   |
| DATE REC'D BY LOCAL REGISTRAR  |  | REGISTRAR'S SIGNATURE  |   |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |   |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |   |



6357

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH:   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED  |  |
| COUNTY <u>Balto</u>  | MARYLAND   | STATE <u>md</u>  | COUNTY <u>Balto</u>                      |
| CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)  | LENGTH OF STAY (in this place)   | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN    |  |
| X TOWN   | 32 yrs   | <u>Annapolis</u>   | X  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |  | STREET ADDRESS (If rural give location)  |  |
| <u>20 Ivy Hall N.H.</u>  |  | <u>37. Blister St</u>  |  |
| 3. NAME OF DECEASED:   |  | 4. DATE OF DEATH:  |  |
| (Type or Print) <u>CHARLES</u>   | (First) (Middle) (Last) <u>KELLY</u>   | (Month) (Day) (Year) <u>July 19 1955</u>   |  |
| 5. SEX   | 6. COLOR OR RACE:  | 7. SINGLE MARRIED. <u>WIDOWED</u> DIVORCED.                                      | 8. DATE OF BIRTH:                        |
| <u>male</u>  | <u>White</u>   | (Specify)  | <u>April 14-1874</u>                     |
| 9. AGE last birthday   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  | 11. BIRTHPLACE (State or foreign country):                                       | 12. CITIZEN OF WHAT COUNTRY?             |
| 81 yrs   | <u>Watchman B &amp; O.R.R. Retired 10 yrs</u>  | <u>Canada</u>  | <u>USA</u>                               |
| 13. FATHER'S NAME:   | 14. MOTHER'S MAIDEN NAME:  | 15. INFORMANT & ADDRESS:   |  |
| <u>Joseph T. Kelly</u>   | <u>Hannah Tapley</u>   | <u>Mrs Bessie Delp 37. Blister St Balto. 20</u>                                  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  | 17. SOCIAL SECURITY NO.  | 18. MEDICAL CERTIFICATION  |  |
| <u>No</u>  | <u>705-09-4304</u>   | I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                               |  |
| IMMEDIATE CAUSE  |  | (A) <u>Coronary occlusion</u>  |  |
| ANTECEDENT CAUSE (B)   |  | DUE TO   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |  | (B) <u>Arterio-sclerotic cerebro-cardio-vascular disease</u>                     |  |
|  |  | DUE TO   |  |
|  |  | (C)  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH  |  |  |  |
| 19A. DATE OF OPERATION:  | 19B. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   | 21C. WHERE DID (City or town) (County) (State)                                   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |
|  |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>Jan.</u> , 1955, to <u>July</u> , 1955, that I last saw the deceased alive on <u>July 18</u> , 1955, and that death occurred at <u>7:30 A</u> M, from the causes and on the date stated above. |  |  |  |
| SIGNATURE <u>Lucia Semeroff</u>  |  | DATE SIGNED <u>7/19/55</u>   |  |
| M.D. <u>1437 Fawcett Ave Balto, Md</u>   |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   | DATE THEREOF   | NAME OF CEMETERY OR CREMATORY  | LOCATION (City, town, or county) (State) |
| <u>Burial</u>  | <u>7/22/55</u>   | <u>Camp Chapel Meth.</u>   | <u>Balto md</u>                          |
| DATE REC'D BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE  | 24. FUNERAL DIRECTOR   | ADDRESS                                  |
| <u>7/24/55</u>   | <u>David Hurley</u>  | <u>Lorraine Funeral Home</u>   | <u>7401 Belair Rd</u>                    |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

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## CERTIFICATE OF DEATH

Reg. Dist. No. 37

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |
| COUNTY <u>Baltimore</u> MARYLAND   | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | STATE <u>Md</u> COUNTY <u>3401-4</u>   | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> |
| X TOWN <u>Cockeysville Md</u>  | LENGTH OF STAY (in this place) <u>13 yrs, 8 months</u>                                 | OR TOWN <u>Baltimore</u>   | STREET ADDRESS (If rural give location) <u>4304 Main Ave</u>                           |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Masonic Home</u>  |  | 4. DATE (Month) (Day) (Year) OF DEATH <u>July 15 1955</u>  |  |
| 3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>A. Albert Kern</u>   |  | 5. AGE last birthday <u>3</u> IF UNDER 1 YEAR: Months Days Hours Min.  |  |
| 6. SEX <u>Male</u>   | 7. COLOR OR RACE <u>White</u>  | 8. DATE OF BIRTH <u>Feb. 17-1863-92</u>  | 9. AGE last birthday <u>3</u> IF UNDER 1 YEAR: Months Days Hours Min.                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Legal office accountant</u>   | 10B. KIND OF BUSINESS OR INDUSTRY <u>Kingdom Wurtenburg Germany</u>                    | 11. BIRTHPLACE (State or foreign country) <u>Kingdom Wurtenburg Germany</u>  | 12. CITIZEN OF WHAT COUNTRY? <u>German</u>   |
| 13. FATHER'S NAME: <u>A. John Kern</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Christiane Bauer</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>None</u>  |  |
| 17. INFORMANT & ADDRESS <u>Wm. H. Kern</u>   |  | 18. MEDICAL CERTIFICATION  |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 420.1 IMMEDIATE CAUSE (A) <u>Coronary Arteriosclerosis</u>   |  |  |  |
| ANTECEDENT CAUSE (B) DUE TO  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)  |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |  |  |
| 19A. DATE OF OPERATION:  |  | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE (Home, farm, factory, street, office bldg. etc.)  |  |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?   |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>49</u> to <u>July 5</u> , 19 <u>55</u> that I last saw the deceased alive on <u>July 11</u> , 19 <u>55</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above. |  |  |  |
| SIGNATURE <u>Walter T. Kern</u>  |  | ADDRESS <u>Cockeysville Md</u> DATE SIGNED <u>July 18 1955</u>   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | DATE THEREOF <u>July 18 1955</u>   |  |
| NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cemetery</u>   |  | LOCATION (City, town, or county) (State) <u>Baltimore Md</u>   |  |
| DATE REC'D BY LOCAL REGISTRAR <u>7-19-55</u>   |  | REGISTRAR'S SIGNATURE <u>Wm. H. Kern</u>   |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS <u>Wm. H. Kern</u>   |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06357

6353

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

|   |                           |   |                                   |
|---|---------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH-<br>COUNTY BALTIMORE  |                           | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE MARYLAND COUNTY BALTIMORE           |                                   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN ESSEX                     |                           | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN ESSEX |                                   |
| HOSPITAL OR<br>INSTITUTION OR<br>STREET ADDRESS 212 RIVERSIDE DRIVE                                     |                           | STREET ADDRESS (If rural, give location)<br>212 RIVERSIDE DRIVE                     |                                   |
| 3. NAME OF DECEASED<br>(Type or Print) MARY A. KNAPP  |                           | 4. DATE OF DEATH JULY 9, 1955   |                                   |
| 5. SEX<br>female  | 6. COLOR OR RACE<br>white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW                              | 8. DATE OF BIRTH<br>AUG. 12, 1864 |
| 9. AGE last birthday<br>70 yrs.   |                           | 10. BIRTHPLACE (State or foreign country)<br>GERMANY                                |                                   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE |                           | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                                   |
| 13. FATHER'S NAME<br>PETER KLEIN  |                           | 14. MOTHER'S MAIDEN NAME<br>WALBURGER ?   |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>NO                                 |                           | 16. SOCIAL SECURITY No.<br>NONE   |                                   |
| 17. INFORMANT AND ADDRESS<br>MRS HARRY M. STAYLOR   |                           | 18. SAME<br>SAME  |                                   |

|   |   |  |
|---|---|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| Immediate cause (a) Cerebral apoplexy   |   | Sudden   |
| Antecedent cause(s) (b) Arteriosclerotic Cardio-Vascular disease  |   | 2 yrs  |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)                                |   |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |   |  |
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)   | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY                                 | (CITY OR TOWN) (COUNTY) (STATE)  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR?  |

22. I hereby certify that I attended the deceased from July 8, 1955, to July 9, 1955, that I last saw the deceased alive on July 9, 1955, and that death occurred at 10 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION  
REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BURIAL  
DATE REG'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

July 12-55

A.W. Hedrich

HENRY SANDER &amp; SONS INC.

BALTIMORE MARYLAND.

dmr.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



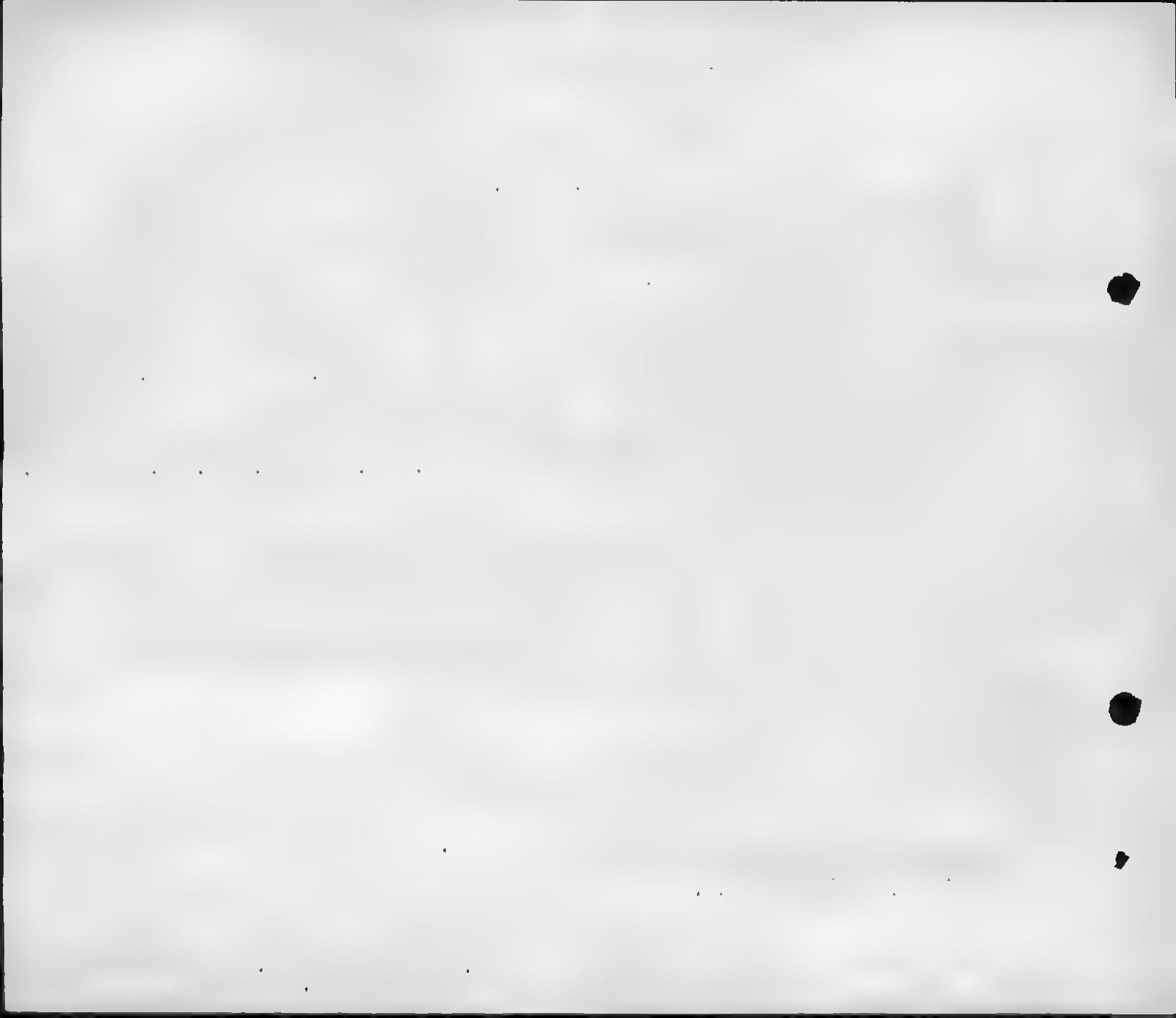
## 6360 CERTIFICATE OF DEATH

Reg. Dist. No. 44

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH:   |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |   |
| COUNTY <u>Baltimore</u>  | MARYLAND  | STATE <u>Maryland</u> COUNTY <u>12</u>  |   |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   | LENGTH OF STAY (in this place)  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN |   |
| <input checked="" type="checkbox"/> TOWN <u>Fort Howard</u>  | <u>20 Hrs. 45 Min.</u>  | <u>Pikesville</u>   | <input checked="" type="checkbox"/>   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |   | STREET ADDRESS (If rural give location)                                       |   |
| <u>50 Veterans administration Hospital</u>   |   | <u>610 Upland Road</u>  |   |
| 3 NAME OF DECEASED: (First) (Middle) (Last)  | 4 DATE (Month) (Day) (Year)   |   |   |
| <u>CHARLES R. KNOFF</u>  | DATE OF DEATH <u>July 17, 1955</u>  |   |   |
| 5 SEX: <u>Male</u>   | 6. COLOR OR RACE: <u>White</u>  | 7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)                               | 8. DATE OF BIRTH <u>7/7/93</u>  |
|  |   |   | 9. AGE (last birthday) IF UNDER 1 YEAR Months Days Hours Min. <u>62 yrs</u> |
| 10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Barber</u>  | 10B KIND OF BUSINESS OR INDUSTRY: <u>Barber Shop</u>  | 11 BIRTHPLACE (State or foreign country): <u>Pottstown, Pa.</u>               | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>                                |
| 13 FATHER'S NAME: <u>Stephen Knopf</u>   | 14. MOTHER'S MAIDEN NAME: <u>Ellen Dwyer</u>  |   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service: <u>WW I</u>  | 16 SOCIAL SECURITY NO.: <u>159-05-2209</u>  | 17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>  |   |
| 18 MEDICAL CERTIFICATION   |   |   |   |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH  |   |
| IMMEDIATE CAUSE (A) <u>PERITONITIS, GENERALIZED</u>  |   | <u>24 HOURS</u>   |   |
| ANTECEDENT CAUSE (S) DUE TO <u>PERFORATION, CHRONIC GASTRIC ULCER</u>  |   | <u>UNKNOWN</u>  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |   |   |   |
| (B) DUE TO   |   |   |   |
| (C)  |   |   |   |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |   | <u>OLD AND NEW INFARCTION OF MYOCARDIUM</u>                                   |   |
| 19A DATE OF OPERATION:   |   | 19B. MAJOR FINDINGS OF OPERATION  |   |
|  |   |   |   |
| 21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21B PLACE (Home, farm, factory, office bldg., etc.) OF INJURY   | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)                  |   |
|  |   |   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |   |
|  |   |   |   |
| 22. I hereby certify that I attended the deceased from <u>July 16, 1955, to July 17, 1955.</u> and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above. |   |   |   |
| SIGNATURE <u>WILLIAM B. VANDEGRIFT, M.D.</u>   |   | ADDRESS <u>M O VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>7-18-55</u>      |   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   | DATE THEREOF  | NAME OF CEMETERY OR CREMATORY   | LOCATION (City, town, or county) (State)                                    |
| <u>Burial</u>  | <u>7-20-55</u>  | <u>Baltimore National Cemetery</u>  | <u>Baltimore, Maryland</u>  |
| DATE REC'D BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE   | M. O. CONRAD PIGHT, Inc. 6009 Harford Road Baltimore 14, Md.                  |   |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

06259

6361

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>COUNTY <u>Baltimore</u><br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>Long Beach, Middle River</u><br>OR TOWN <u>Long Beach, Middle River</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Law</u> |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Maryland</u> COUNTY <u>B...</u><br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>OR TOWN <u>Baltimore</u><br>STREET ADDRESS <u>2712 Ruckert Ave.</u> |   |
| 3. NAME OF DECEASED<br>(Type or Print) <u>SYLVIA</u> (First) <u>M.</u> (Middle) <u>KRAWCZYK</u> (Last)   |                               | 4. DATE OF DEATH<br>(Month) <u>7</u> (Day) <u>15</u> (Year) <u>1955</u>  |   |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>   | 8. DATE OF BIRTH<br><u>Dec. 24 1935</u> |
| 9. AGE last birthday <u>19</u> yrs.  |                               | 10. BIRTHPLACE (State or foreign country) <u>Baltimore - Md</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore - Md</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>STEVEN G. Krawczyk</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>ANNA J. Chrobocinski</u>   |   |
| 15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <u>FATHER</u>  |   |
| 17. INFORMANT AND ADDRESS <u>SAMC</u>  |                               |  |   |

## II. MEDICAL CERTIFICATION

|  |  |                                  |
|--|--|----------------------------------|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH |
| <u>850X</u><br>Immediate cause (a) <u>DROWNING</u>   |  |                                  |
| Antecedent cause(s)<br>Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) |  |                                  |

|  |  |
|--|--|
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death |  |
|--|--|

|                        |                                  |   |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|---|

|   |  |   |          |         |
|---|--|---|----------|---------|
| 21. EXTERNAL CAUSE WAS PRIMARY FOR CONTRIBUTING CAUSE OF DEATH    | PLACE (Home, farm, factory, street, OF INJURY (Three blocks, etc.)   | (CITY OR TOWN)                                | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-15-55 1:45 pm</u> | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | HOW DID INJURY OCCUR? <u>Fell from Cruise</u> |          |         |

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐

|   |                       |                                  |                                  |                            |
|---|-----------------------|----------------------------------|----------------------------------|----------------------------|
| SIGNATURE <u>M.D. Davis</u> (Degree or title) |                       | ADDRESS <u>2712 Ruckert Ave.</u> |                                  | DATE SIGNED <u>7/15/55</u> |
| 23. BURIAL, CREMATION REMOVAL (Specify)       | DATE THEREOF          | NAME OF CEMETERY OR CREMATOR     | LOCATION (City, town, or county) | (State)                    |
| <u>Burial</u>                                 | <u>7-19-55</u>        | <u>Holy Redeemer</u>             | <u>BALTO</u>                     | <u>Md</u>                  |
| DATE REC'D BY LOCAL REG.                      | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR             | ADDRESS                          |                            |
| <u>7/18/55</u>                                | <u>A.A. Hedrick</u>   | <u>Edward Leonard</u>            | <u>3305 Bayford</u>              |                            |



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06360

6362

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

|  |                                |   |   |
|--|--------------------------------|---|---|
| 1. PLACE OF DEATH:<br>COUNTY <u>BALTO.</u> MARYLAND  |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>MD.</u> COUNTY <u>BALTO.</u>                                     |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>X</u> TOWN <u>SPARROWS POINT</u> LENGTH OF STAY (in this place) <u>45 yrs.</u> |                                | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>SPARROWS POINT</u> <u>191 X</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>813 F STREET</u>  |                                | STREET ADDRESS (If rural, give location) <u>813 F ST.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or Print)   | (First) <u>MARY</u>            | (Middle) <u>GREELY</u>  | (Last) <u>KREPP</u>                                       |
| 4. DATE OF DEATH   | (Month) <u>JULY</u>            | (Day) <u>11</u>   | (Year) <u>1953</u>  |
| 5. SEX <u>FEM.</u>   | 6. COLOR OR RACE <u>WHITE.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>  | 8. DATE OF BIRTH <u>MAY 5 1883</u>                        |
| 9. AGE last birthday <u>72</u> yrs.  |                                | 10. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>   | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>  |                                | 13. FATHER'S NAME <u>THOMAS GREELY</u>  |   |
| 14. MOTHER'S MAIDEN NAME <u>JULIA FLANNERY</u>   |                                | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |   |
| 16. SOCIAL SECURITY No. <u>NONIE</u>   |                                | 17. INFORMANT AND ADDRESS <u>MISS MARY A. KREPP - SAME ADDRESS</u>  |   |

|  |                                  |
|--|----------------------------------|
| 18. MEDICAL CERTIFICATION  |                                  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause <u>443X</u> (a) <u>Cardiac Failure (chronic)</u>   | <u>3 yrs.</u>                    |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Hypertensive Arteriosclerotic cardiovascular disease</u> | <u>16 yrs.</u>                   |
| (c)  |                                  |

|   |   |
|---|---|
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |   |
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION  |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE   | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY                                 |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |
| HOW DID INJURY OCCUR?   |   |

22. I hereby certify that I attended the deceased from July 1, 1953, to July 11, 1953, that I last saw the deceased alive on July 11, 1953, and that death occurred at 10 P m., from the causes and on the date stated above.

|  |  |  |  |
|--|--|--|--|
| SIGNATURE <u>David Owens</u>                         | (Degree or title) <u>M.D.</u>                | ADDRESS <u>914 D Street Balto. Md.</u>             | DATE SIGNED <u>7/12/53</u>                         |
| 23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u> | DATE THEREOF <u>JULY 14 1953</u>             | NAME OF CEMETERY OR CREMATORY <u>FOLT CEMETARY</u> | LOCATION (City, town, or county) <u>BALTO. MD.</u> |
| DATE REC'D BY LOCAL REG. <u>July 12-53</u>           | REGISTRAR'S SIGNATURE <u>Dawson L. Parbr</u> | 24. FUNERAL DIRECTOR                               | ADDRESS  |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3

4

5

6



06961

## MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

654

|  |                               |  |                                       |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH-<br>COUNTY <b>Baltimore</b> MARYLAND   |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <b>Maryland</b> COUNTY <b>1</b>      |                                       |
| CITY (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>                               |                               | CITY (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>9 Lombardy Drive</b>  |                               | STREET ADDRESS (If rural, give location) <b>9 Lombardy Drive</b>                     |                                       |
| 3. NAME OF DECEASED (First) <b>SOPHIE</b> (Middle) <b>KRESSLER</b> (Last) <b>KRESSLER</b>                          |                               | 4. DATE OF DEATH (Month) <b>July</b> (Day) <b>22</b> (Year) <b>1955</b>              |                                       |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>                      | 8. DATE OF BIRTH <b>Nov. 12, 1878</b> |
| 9. AGE last birthday <b>76</b> yrs.  |                               | 10. If under 1 year: Months <b>1</b> Days <b>22</b> Hours <b>19</b> Min. <b>55</b>   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>       |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>                                     |                                       |
| 11. BIRTHPLACE (State or foreign country) <b>Germany</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                       |
| 13. FATHER'S NAME <b>John Petrowski</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>unknown</b>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) |                               | 16. SOCIAL SECURITY NO. <b>none</b>  |                                       |
| 17. INFORMANT <b>Mr. Herman Kressler</b>   |                               |  |                                       |

18. MEDICAL CERTIFICATION **9 Lombardy Drive**

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause (a) **Uterus - + cirrhotic Arteriosclerosis**

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) **hypertension**

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.19a. DATE OF OPERATION **July 26, 1955** 19b. MAJOR FINDINGS OF OPERATION **hypertension**

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING ☐ PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY **m.** INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) **burial** DATE THEREOF **July 26, 1955** NAME OF CEMETERY OR CREMATORY **Immanuel Luth. Cem.** LOCATION (City, town, or county) (State) **Scranton, - Pennsylvania**

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

**July 26, 1955** **H. SANDER & SONS, INC.** **Baltimore, Maryland**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. A. RYAN

10-1-1914

6363

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH:  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |  |
| COUNTY <u>Baltimore</u>   | MARYLAND                                       | STATE <u>Ba</u>   | COUNTY   |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard (19) 29440</u>   | LENGTH OF STAY (in this place)                 | CITY (If outside corporate limits, write RURAL and give nearest town) <u>md</u> | X  |
| TOWN <u>Howard Ave + old Bay Rd</u>   |  | TOWN  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Howard Ave + old Bay Rd</u>  |  | STREET ADDRESS (If rural give location) <u>#1</u>                               |  |
| 3. NAME OF DECEASED:  |  | 4. DATE OF DEATH:   |  |
| (Type or Print) <u>Alexandra</u>  | (First) <u>Sabuda</u>                          | (Month) <u>July</u>   | (Day) <u>17</u>  |
| 5. SEX: <u>Female</u>   | 6. COLOR OR RACE: <u>white</u>                 | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>                  | 8. DATE OF BIRTH: <u>Sept 14, 1882</u>   |
| 9. AGE last birthday: <u>72</u> yrs.  | 10. AGE last birthday: <u>72</u> yrs.          | 11. AGE last birthday: <u>72</u> yrs.   | 12. AGE last birthday: <u>72</u> yrs.  |
| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>housewife</u>  | 10b. KIND OF BUSINESS OR INDUSTRY: <u>home</u> | 11. BIRTHPLACE (State or foreign country): <u>Poland</u>                        | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |
| 13. FATHER'S NAME: <u>Martin Golebiewski</u>  |  | 14. MOTHER'S MAIDEN NAME: <u>Josephine Knoch</u>                                |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>  |  | 16. SOCIAL SECURITY No.: <u>none</u>  |  |
| 17. INFORMANT'S ADDRESS: <u>Jos. Sabuda address as in #1</u>  |  |   |  |
| 18. MEDICAL CERTIFICATION   |  |   |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |   | Interval Between Onset and Death   |
| Immediate cause <u>442X</u> <u>Cerebral hemorrhage</u>  |  |   | <u>11 days</u>   |
| Antecedent causes (s) <u>Hypertensive cardiovascular disease and arteriosclerosis</u>   |  |   | <u>8 yrs.</u>  |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. <u>Diabetes mellitus</u>  |  |   | <u>5 yrs.</u>  |
| 11. OTHER SIGNIFICANT CONDITIONS <u>diabetic ulcers</u>   |  |   | <u>4 days</u>  |
| 19a. DATE OF OPERATION:   |  |   | 19b. MAJOR FINDINGS OF OPERATION   |
| 21. ACCIDENT (Specify) <u>SUICIDE</u>   |  |   | 22. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/> |
| PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>   |  |   |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>  |  |   |  |
| INJURY OCCURRED <u>White at Work</u> <input type="checkbox"/> <u>Not While At Work</u> <input type="checkbox"/>   |  |   |  |
| HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>1927</u> to <u>July 17, 1955</u> , that I last saw the deceased alive on <u>July 17, 1955</u> , and that death occurred at <u>4:26 P.M.</u> from the causes and on the date stated above. |  |   |  |
| SIGNATURE (Name and title) <u>Louis H. Tallin M.D.</u> ADDRESS <u>6908 North P Rd Balto. 19</u> DATE SIGNED <u>July 17, 1955</u>  |  |   |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | DATE THEREOF <u>JULY 17, 1955</u>   | NAME OF CEMETERY OR CREMATORY <u>HOLY REDEMMER</u>   |
| LOCATION (City, town, or county) <u>BALTO. MD.</u>  |  | (State)   |  |
| DATE REC'D BY LOCAL REGISTRAR <u>July 20, 1955</u>  |  | REGISTRAR'S SIGNATURE <u>W. Dawson Fisher</u>                                   |  |
| 24. FUNERAL DIRECTOR <u>W. H. Knott Knottley, Randolph, Md.</u>   |  | ADDRESS   |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. DEPARTMENT OF AGRICULTURE



## MARYLAND STATE DEPARTMENT OF HEALTH

06363

2411 N. Charles Street, Baltimore

6265

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>COUNTY <u>Baltimore</u>   |  | MARYLAND  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>B31 Circle Drive</u> COUNTY <u>Baltimore</u> |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Halethorpe</u>  |  | LENGTH OF STAY<br>(In this place)   |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>(27)</u>      |  |
| HOSPITAL OR<br>INSTITUTION OR<br>STREET ADDRESS  |  |   |  | STREET ADDRESS<br><u>1231 Circle Drive</u>   |  |
| 3. NAME OF DECEASED<br>(Type or Print) <u>Edward</u>   |  | (Middle) <u>E</u>   |  | (Last) <u>LAVENDER</u>   |  |
| 4. DATE OF DEATH<br>(Month) <u>July</u> (Day) <u>8</u> (Year) <u>1955</u>  |  | 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>W</u>   |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED.<br>(Specify) <u>Married</u>   |  | 8. DATE OF BIRTH<br><u>Oct 29 - 1883</u>  |  | 9. AGE last birthday<br><u>71</u> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Printer</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>MD</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 13. FATHER'S NAME<br><u>John Lavender</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY No.<br><u>216-10-1898</u>   |  | 17. INFORMANT<br><u>Edward Lavender - Oakland Rd.</u>  |  |
| 18. MEDICAL CERTIFICATION  |  |   |  |  |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |   |  |  |  |
| Immediate cause (a) <u>Coronary Thrombosis</u>   |  |   |  |  |  |
| Antecedent cause(s) (b) <u>Coronary Disease</u>  |  |   |  |  |  |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Coronary Disease</u>   |  |   |  |  |  |
| 2. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION  |  |  |  |
| 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |   |  |  |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  |  | PLACE (Home, farm, factory, street, OF office bldg., etc.)  |  | (CITY OR TOWN) (COUNTY) (STATE)  |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <u>7/18/55</u> to <u>7/18/55</u> , that I last saw the deceased alive on <u>7/18/55</u> , and that death occurred at <u>11:15</u> m., from the causes and on the date stated above. |  |   |  |  |  |
| SIGNATURE<br><u>Joseph L. Lankford</u>   |  | DATE THEREOF<br><u>July 22 - 55</u>   |  | NAME OF CEMETERY OR CREMATORY<br><u>New York City</u>  |  |
| LOCATION (City, town, or county) (State)<br><u>NY</u>  |  | DATE REC'D BY LOCAL REG.<br><u>7/20/55</u>  |  | FURNERAL DIRECTOR<br><u>Edmund A. Hedrick</u>  |  |
| ADDRESS<br><u>1231 Circle Drive</u>  |  |   |  |  |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

636

Item 7, File 3184 8-3-55

## CERTIFICATE OF DEATH

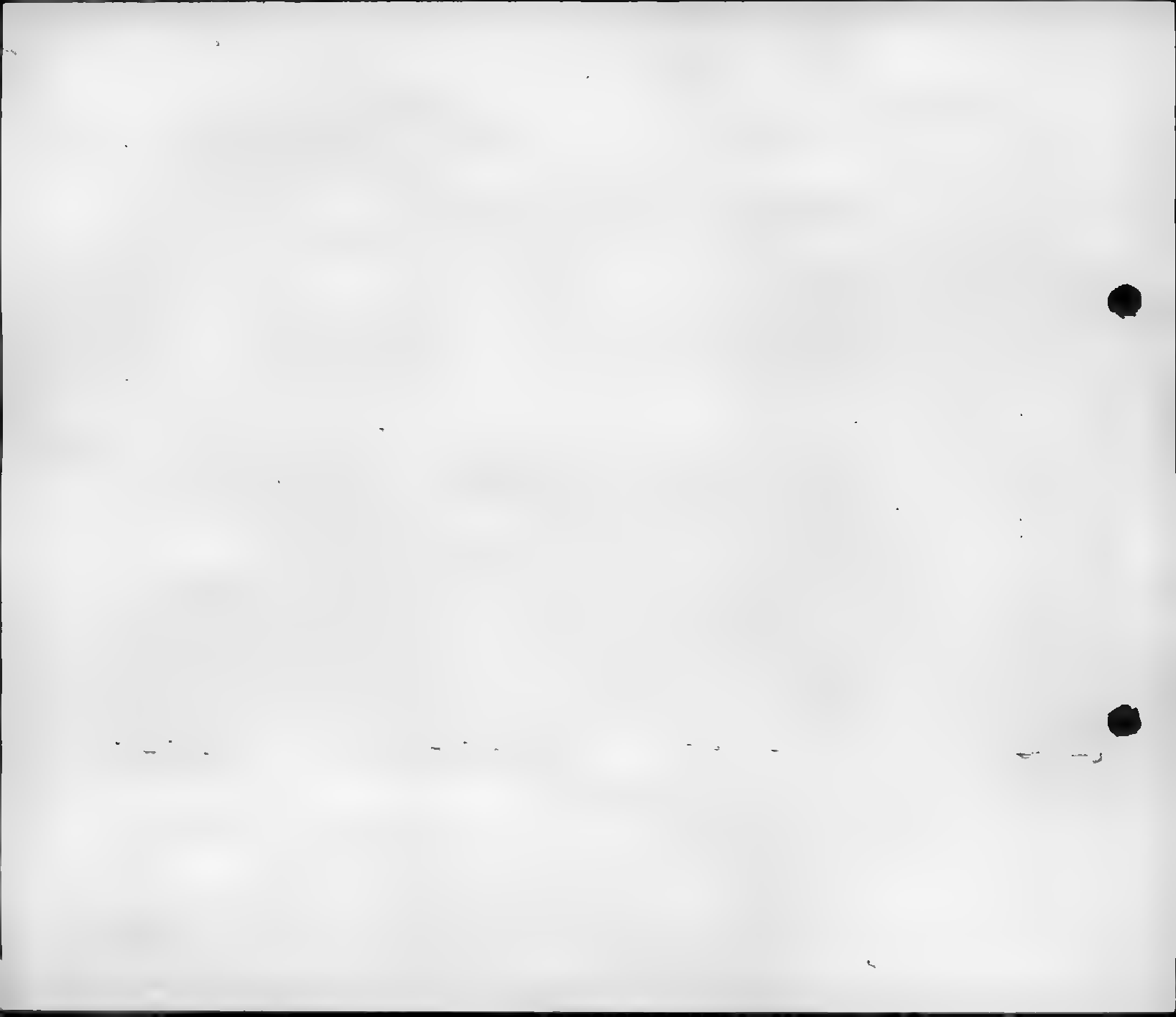
Reg. Dist. No.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH   |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED   |  |   |  |
| COUNTY <b>Baltimore City</b>  |  | STATE <b>Maryland</b>  |  | COUNTY <b>Balto. City</b>   |  |   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>   |  | LENGTH OF STAY (in this place) <b>2 yr, 7 mos.</b>   |  | CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 29</b> |  |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spring Grove State Hosp.</b>   |  | STREET ADDRESS (If rural give location) <b>3513 Gelstone Drive</b>   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or Print) <b>Margaret</b>   |  | (First) (Middle) (Last) <b>Lepson</b>  |  | 4. DATE OF DEATH: <b>7</b> <b>27</b> <b>1955</b>  |  |   |  |
| 5. SEX <b>F</b>   |  | 6. COLOR OR RACE <b>W</b>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed married</b>                   |  | 8. DATE OF BIRTH <b>Feb. 21, 1882</b>                               |  |
| 9. AGE last birthday <b>73</b> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                 |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>                            |  |
| 13. FATHER'S NAME: <b>Louis Chaillou</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Helen V. McGahan</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>   |  |  |  | 16. SOCIAL SECURITY NO. <b>William Lepson</b>   |  |   |  |
| 17. INFORMANT & ADDRESS: <b>3601 Essex Road., Balto. 7, Md.</b>   |  |  |  |   |  |   |  |
| 18. MEDICAL CERTIFICATION   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH                                    |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (A) <b>Cerebro-vascular accident due to</b>   |  |  |  |   |  | <b>4 days</b>   |  |
| ANTECEDENT CAUSE (B) <b>arteriosclerotic cardio-vascular</b>  |  |  |  |   |  | <b>years</b>  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>disease.</b>   |  |  |  |   |  |   |  |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |  |  |   |  |   |  |
| 19A. DATE OF OPERATION:   |  |  |  | 19B. MAJOR FINDINGS OF OPERATION  |  |   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                              |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>July 1953</b> to <b>July 27, 1955</b> that I last saw the deceased alive on <b>July 26, 1955</b> , and that death occurred at <b>12:45 a.m.</b> from the causes and on the date stated above. |  |  |  |   |  |   |  |
| SIGNATURE <b>G. Wachsler</b>  |  | ADDRESS <b>Spring Grove State Hospital</b>   |  | DATE <b>7-27-55</b>   |  |   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | DATE THEREOF <b>July 30, 55</b>  |  | NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>                               |  | LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b> |  |
| DATE REC'D BY LOCAL REGISTRAR   |  | REGISTRAR'S SIGNATURE  |  | 24. FUNERAL DIRECTOR <b>Elesworth Annacost</b>  |  | ADDRESS <b>4000 Liberty Heights Avenue</b>                          |  |

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





Reg. Dist. No.

|  |                        |  |                       |
|--|------------------------|--|-----------------------|
| DATE RECEIVED BY: <u>LOCAL REGISTRAR</u> | REGISTRAR'S SIGNATURE  | 23. FUNERAL DIRECTOR                       | ADDRESS               |
| <u>Aug 4, 1955</u>                       | <u>Wm. G. Williams</u> | <u>Wm. J. Scherer Bros. - Dallas, Tex.</u> | <u>17 N. Main St.</u> |

BIRKENHEAD

16

10/11

06266

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

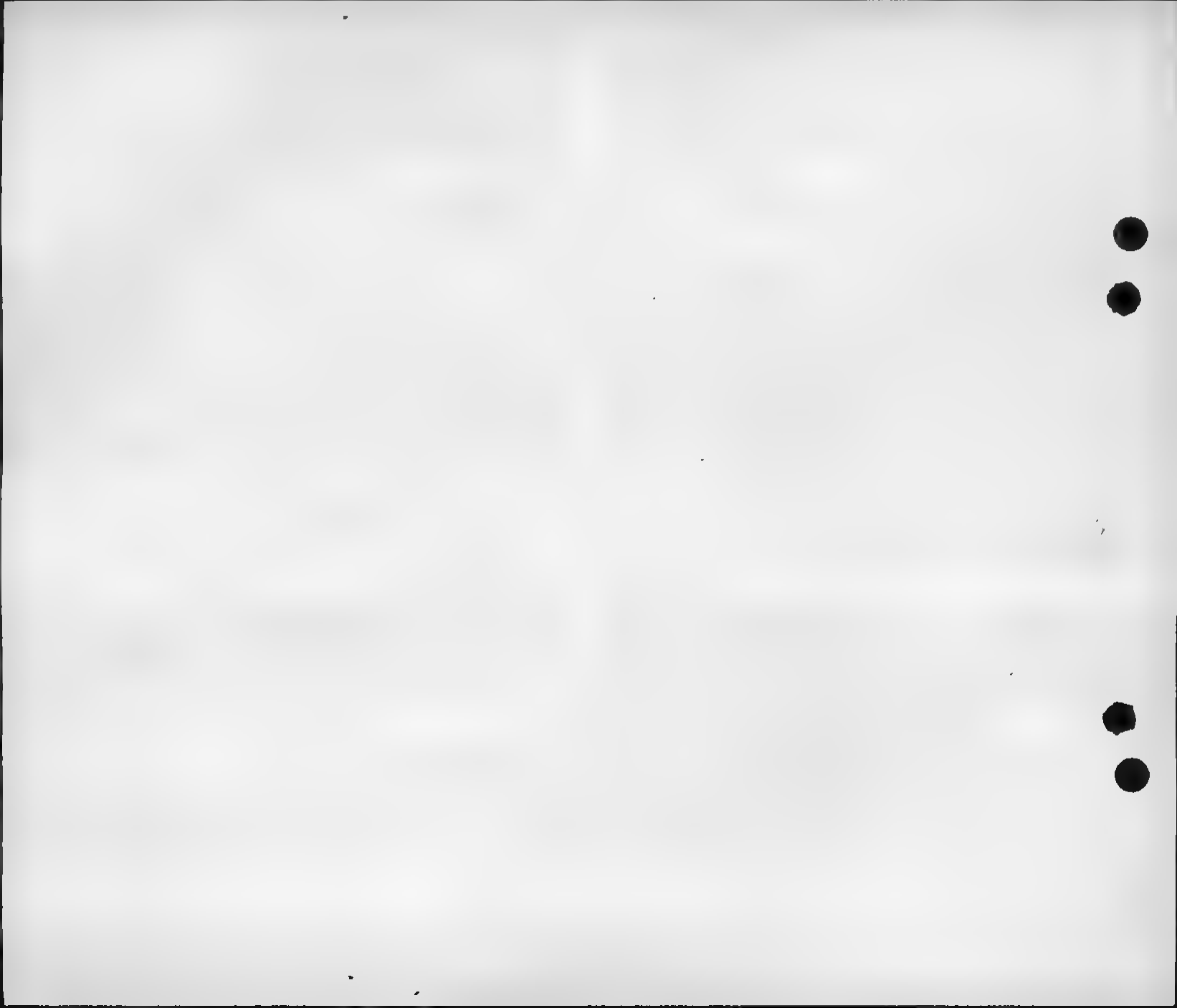
6369

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH-<br>COUNTY <b>Baltimore</b>   |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <b>Maryland</b> COUNTY <b>/</b>                              |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWN</b>  |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWN</b>                         |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>59 Rockaway Beach Avenue</b>  |                                  | STREET ADDRESS (If rural, give location)<br><b>59 Rockaway Beach Avenue</b>                                  |   |
| 3. NAME OF DECEASED<br>(Type or Print)  | (First) <b>Sebastian</b>         | (Middle) <b>J.</b>   | (Last) <b>Linz</b>                      |
| 4. DATE OF DEATH  | (Month) <b>July</b>              | (Day) <b>11</b>  | (Year) <b>1955</b>                      |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED<br>(Specify) <b>Married</b>  | 8. DATE OF BIRTH<br><b>Dec. 1, 1887</b> |
| 9. AGE last birthday<br><b>67</b> yrs.  |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b> |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Baltimore</b>   |   |
| 13. FATHER'S NAME<br><b>John Linz</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Eva Hock</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY No.  |   |
| 17. INFORMANT AND ADDRESS<br><b>John S. Linz 15 Fir Drive</b>   |                                  | 18. MEDICAL CERTIFICATION  |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><b>181X Immediate cause</b> (a).... <b>Carcinoma of Bladder</b><br><b>Antecedent cause(s)</b> (b).... <b>Generalized metastasis</b><br>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c).... |                                  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |                                  |  |   |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |                                  |  |   |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)   |                                  | PLACE (Home, farm, factory, street, office bldg., etc.)<br><b>INJURY</b>                                     |   |
| (CITY OR TOWN)  |                                  | (COUNTY)   |   |
| (STATE)   |                                  |  |   |
| TIME (Month) (Day) (Year) (Hour)<br>OF INJURY   |                                  | INJURY OCCURRED<br>While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>         |   |
| HOW DID INJURY OCCUR?   |                                  |  |   |
| 22. I hereby certify that I attended the deceased from <b>6-15, 1949</b> to <b>7-11, 1955</b> , that I last saw the deceased alive on <b>7-11, 1955</b> and that death occurred at <b>2:20</b> Am., from the causes and on the date stated above.   |                                  |  |   |
| SIGNATURE<br><b>Edward A. Blangan Jr.</b>   |                                  | DATE SIGNED<br><b>7/13/55</b>  |   |
| 23. BURIAL, CREMATION REMOVAL (Specify)<br><b>Burial</b>  |                                  | DATE THEREOF<br><b>July 11, 1955</b>   |   |
| NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart</b>  |                                  | LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                       |   |
| 24. FUNERAL DIRECTOR<br>- REG.  |                                  | ADDRESS<br><b>Lilly &amp; Zeiler Inc., 403 S. Wolfe St.</b>  |   |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No.

Reg. Dist.

|   |   |  |                                      |
|---|---|--|--------------------------------------|
| 1. PLACE OF DEATH:  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                                      |
| COUNTY <i>Balto.</i>  | MARYLAND  | STATE  | COUNTY                               |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <i>Essex, Balto. 21</i>   | LENGTH OF STAY (in this place)<br><i>1 1/2 yrs.</i> | CITY (If outside corporate limits write RURAL and give nearest town)<br>TOWN                 | <i>Same</i>                          |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1713 Langley Rd.</i>   |   | STREET ADDRESS (If rural, give location)   |                                      |
| 3. NAME OF DECEASED:<br>(Type or Print) <i>Katherine Englebert Rummie</i>   |   | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><i>July 30 1955</i>                              |                                      |
| 5. SEX: <i>Female</i>   | 6. COLOR OR RACE: <i>White</i>                      | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Married</i>                              | 8. DATE OF BIRTH: <i>Nov 30/1878</i> |
| 9. AGE last birthday: <i>76</i> yrs.  |   | 10. AGE last birthday: <i>IF UNDER 1 YEAR</i> Months Days <i>IF UNDER 24 HRS.</i> Hours Min. |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Housewife (Retired)</i>  |   | 10b. KIND OF BUSINESS OR INDUSTRY: <i>Gutenberg, N. J.</i>                                   |                                      |
| 11. BIRTHPLACE (State or foreign country): <i>Gutenberg, N. J.</i>  |   | 12. CITIZEN OF WHAT COUNTRY?   |                                      |
| 13. FATHER'S NAME: <i>George Hoekler</i>  |   | 14. MOTHER'S MAIDEN NAME: <i>Dorothy</i>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>  |   | 16. SOCIAL SECURITY No.: <i>None</i>   |                                      |
| 17. INFORMANT & ADDRESS: <i>Mrs. Dorothy Dauford (daughter)</i>   |   |  |                                      |
| 18. MEDICAL CERTIFICATION   |   |  |                                      |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  |   | INTERVAL BETWEEN ONSET AND DEATH   |                                      |
| 423.1<br>Immediate cause (a) ... DUE TO <i>Coronary Occlusion</i>   |   | <i>Indefinite</i>  |                                      |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <i>Cor. Vascular Disease</i>  |   | <i>Unknown</i>   |                                      |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH  |   |  |                                      |
| 19a. DATE OF OPERATION:   |   | 19b. MAJOR FINDING OF OPERATION:   |                                      |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>   |   |  |                                      |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY                       |                                      |
| 21c. (City or town) (County) (State)  |   | 21d. TIME (Month) (Day) (Year) (Hour) OF DEATH: <i>Dec 7-30-55 4A.</i>                       |                                      |
| 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   | 21f. HOW DID INJURY OCCUR?   |                                      |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |  |                                      |
| SIGNATURE <i>M. D. Rummie</i>   |   | DATE SIGNED <i>Aug 1 1955</i>  |                                      |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <i>Buried</i>   |   | DATE THEREOF <i>Aug 1/55</i>   |                                      |
| NAME OF CEMETERY OR CREMATORY <i>Louisa Park Cemetery</i>   |   | LOCATION (City, town, or county) (State) <i>Balto. Co. Md.</i>                               |                                      |
| DATE REC'D BY LOCAL REG. <i>Aug 1 1955</i>  |   | 24. FUNERAL DIRECTOR <i>Brzezinski 407 Eastern Ave</i>                                       |                                      |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# THE MORGUE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06268  
6368  
CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                           |  |  |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH<br>COUNTY <u>Catonsville</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Balto County.</u> LENGTH OF STAY (in this place) <u>15 days.</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital</u> |                           | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>Md</u> COUNTY _____<br>CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u><br>STREET ADDRESS (If rural, give location) <u>3219 Walbrook Ave.</u> |  |
| 3. NAME OF DECEASED (Type or Print)<br>(First) <u>MARY</u> (Middle) <u>DEMPSEY</u> (Last) <u>MALONE</u>  |                           | 4. DATE (Month) (Day) (Year)<br>OF DEATH: <u>7</u> <u>22</u> 19 <u>55</u>  |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARR. ED., WIDOWED, DIVORCED, (Specify) <u>Widow</u>  | 8. DATE OF BIRTH <u>5-21-1927?</u>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                           | 10B. KIND OF BUSINESS OR INDUSTRY _____  | 9. AGE last birthday <u>28</u> yrs. Months _____ Days _____ Hours _____ Min. _____ |
| 11. BIRTHPLACE (State or foreign country) <u>USA (West. Va.)</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Michael J Dempsey</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Hilda Malone</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) _____  |                           | 16. SOCIAL SECURITY NO _____   |  |
| 17. INFORMANT & ADDRESS <u>Tele: Longwood 6-2081</u>   |                           |  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. MEDICAL CERTIFICATION<br>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br>IMMEDIATE CAUSE (A) <u>Cerebral Vascular Thrombosis</u><br>ANTECEDENT CAUSE (B) <u>Generalized Arteriosclerosis</u><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Senility</u> |  | INTERVAL BETWEEN ONSET AND DEATH |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>  |  |                                  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION: _____   |  | 19B. MAJOR FINDINGS OF OPERATION _____   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?          |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____   |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR? _____                                      |  |
| 22. I hereby certify that I attended the deceased from <u>7/22/55</u> , 19 <u>55</u> , to <u>7/22/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/22/55</u> , 19 <u>55</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above. |  |  |  |   |  |
| SIGNATURE <u>Spring Grove Hospital - H. Cronin</u>  |  | ADDRESS <u>Spring Grove Hospital</u>   |  | DATE SIGNED <u>7/22/55</u>  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>July 25, 1955 - Buried</u>  |  | DATE THEREOF _____   |  | NAME OF CEMETERY OR CREMATOR _____                                    |  |
| DATE REC'D BY LOCAL REGISTRAR <u>7-25-55</u>  |  | REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  | 24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook Inc</u>                      |  |

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





6369

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH  |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED   |  |  |  |
| COUNTY <u>Baltimore</u>  |  | MARYLAND   |  | STATE <u>Md.</u>  |  | COUNTY   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Catonsville</u>  |  | LENGTH OF STAY (in this place)   |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Baltimore #29 3rd 4</u> |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>14 Spingrove Ave</u>   |  |  |  | STREET ADDRESS (If rural give location)<br><u>913 Colwood Rd.</u>   |  |  |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><u>Mike</u> <u>sup</u> <u>MARKINO</u>  |  |  |  | 4. DATE (Month) (Day) (Year)<br>OF DEATH: <u>1</u> <u>11</u> <u>1955</u>                                    |  |  |  |
| 5. SEX. <u>Male</u>  |  | 6. COLOR OR RACE. <u>W</u>   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>  |  | 8. DATE OF BIRTH. <u>5/4/1878</u>  |  |
| 9. AGE last birthday IF UNDER 1 YEAR   |  | IF UNDER 24 MRS.   |  | 10. AGE last birthday IF UNDER 1 YEAR   |  | IF UNDER 24 MRS.   |  |
| 77 yrs   |  | Months Days Hours Min.   |  | 77 yrs  |  | Months Days Hours Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Businessman</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY. <u>Store owner</u>  |  | 11. BIRTHPLACE (State or foreign country): <u>Italy</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  |
| 13. FATHER'S NAME: <u>Angelo Marino</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME: <u>unknown</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk.</u>  |  |  |  | 16. SOCIAL SECURITY NO. <u>unk.</u>   |  |  |  |
| 17. INFORMANT & ADDRESS: <u>H. Sp. Re...</u>   |  |  |  |   |  |  |  |
| 18. MEDICAL CERTIFICATION  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (A) <u>Heart failure</u>   |  |  |  |   |  | Jus. not with?   |  |
| ANTECEDENT CAUSE (B) <u>Urinary infection</u>  |  |  |  |   |  | unk. on  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Hypertrophy of the prostate</u>   |  |  |  |   |  | unk. on  |  |
| 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u>  |  |  |  |   |  | unk. on  |  |
| 3. <u>Throm. brain syndrome assoc. with some</u>   |  |  |  |   |  | unk. on  |  |
| 19A. DATE OF OPERATION.  |  | 19B. MAJOR FINDINGS OF OPERATION   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|  |  | <u>Brain disease</u>   |  |   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc)  |  | 21C. WHERE DID (City or town) (County) (State)  |  | INJURY OCCUR?  |  |
|  |  |  |  |   |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
|  |  |  |  |   |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>7/18</u> , 1955, to <u>7/19</u> , 1955, that I last saw the deceased alive on <u>7/19</u> , 1955, and that death occurred at <u>4:40</u> AM, from the causes and on the date stated above. |  |  |  |   |  |  |  |
| SIGNATURE  |  | ADDRESS  |  | DATE SIGNED   |  |  |  |
| <u>H. Sp. Re...</u>  |  | <u>M.D. Spingrove St. Hosp.</u>  |  | <u>11-15-55</u>   |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)   |  | DATE THEREOF   |  | NAME OF CEMETERY OR CREMATORY   |  | LOCATION (City, town, or county) (State)   |  |
| <u>Burial</u>  |  | <u>7-22-55</u>   |  | <u>Loudon Park</u>  |  | <u>Baltimore, Md.</u>  |  |
| DATE REC'D BY LOCAL REGISTRAR  |  | REGISTRAR'S SIGNATURE  |  | SPECIAL DIRECTOR  |  | ADDRESS  |  |
| <u>7-20-55</u>   |  | <u>J. E. Harry</u>   |  | <u>Howard H. Hubbard</u>  |  | <u>4107 Wilkens Ave</u>  |  |

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6370

06370

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 30

|   |                   |   |  |  |  |                              |  |
|---|-------------------|---|--|--|--|------------------------------|--|
| 1. PLACE OF DEATH:  |                   |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                       |  |                              |  |
| COUNTY  |                   | MARYLAND  |  | STATE  |  | COUNTY                       |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town).                             |                   | LENGTH OF STAY (In this place)                    |  | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN |  |                              |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                   |   |  | STREET ADDRESS (If rural, give location)                                     |  |                              |  |
| 3. NAME OF DECEASED:  |                   | (First)   |  | (Middle)   |  | (Last)                       |  |
| (Type or Print)   |                   |   |  |  |  | 4. DATE OF DEATH             |  |
|   |                   |   |  |  |  | 19                           |  |
| 5. SEX:   | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): |  | 8. DATE OF BIRTH:  |  | 9. AGE last birthday:        |  |
|   |                   |   |  |  |  | IF UNDER 1 YEAR              |  |
|   |                   |   |  |  |  | Months Days Hours Min.       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):             |                   | 10b. KIND OF BUSINESS OR INDUSTRY:                |  | 11. BIRTHPLACE (State or foreign country):                                   |  | 12. CITIZEN OF WHAT COUNTRY? |  |
| 13. FATHER'S NAME:  |                   |   |  | 14. MOTHER'S MAIDEN NAME:  |  |                              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) |                   |   |  | 16. SOCIAL SECURITY No.:   |  | 17. INFORMANT & ADDRESS:     |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 18. MEDICAL CERTIFICATION  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                            |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |  |  |  |   |  |
| <p>422.1 Immediate cause (a) DUE TO</p> <p>Antecedent cause(s) (b) DUE TO</p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>  |  |  |  |   |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |  |   |  |
| 19a. DATE OF OPERATION:  |  | 19b. MAJOR FINDING OF OPERATION:   |  | 20. AUTOPSY?  |  |
|  |  |  |  | Yes <input type="checkbox"/> No <input type="checkbox"/>    |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY                                 |  | 21c. (City or town) (County) (State)                        |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?                                  |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |  |  |   |  |
| SIGNATURE  |  | 1010 Reids am  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED |  |
|  |  |  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 7-2-55     |  |
|  |  |  |  | ASSISTANT MEDICAL EXAM. <input type="checkbox"/>            |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify):  |  | DATE THEREOF   |  | LOCATION (City, town, or county) (State)                    |  |
| 7-21-55  |  | 7/21/55  |  | Baltimore Md.   |  |
| DATE REC'D BY LOCAL REG.   |  | REGISTRAR'S SIGNATURE  |  | 24. FUNERAL DIRECTOR  |  |
| 7-21-55  |  | T. E. Harris   |  | Francis A. Hendley/Bradley                                  |  |



06371

## MARYLAND STATE DEPARTMENT OF HEALTH

6371

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH-<br>COUNTY <u>Baltimore</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Maryland</u> COUNTY <u>Baltimore</u>           |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Middle River</u>         |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Middle River</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>34 Everlasting Lane</u>                                      |                                  | STREET ADDRESS (If rural, give location)<br><u>34 Everlasting Drive</u>                           |   |
| 3. NAME OF DECEASED<br>(Type or Print)<br>(First) <u>H. Z. L.</u> (Middle) <u>H. Z.</u> (Last) <u>L.</u>  |                                  | 4. DATE OF DEATH<br>(Month) <u>July</u> (Day) <u>31</u> (Year) <u>1955</u>                        |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>                                     | 8. DATE OF BIRTH<br><u>Dec. 4, 1891</u> |
| 9. AGE last birthday<br><u>63</u> yrs.  |                                  | 10. BIRTHPLACE (State or foreign country)<br><u>Michigan</u>                                      |   |
| 11. USUAL OCCUPATION (Give kind of work and during most of working life, even if retired)<br><u>W. W.</u> |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>Own Home</u>   |   |
| 13. FATHER'S NAME<br><u>Patter</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Unterhagen</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY No.<br><u>Carroll Sewell, 34 Everlasting Lane</u>                             |   |

|  |  |                                  |
|--|--|----------------------------------|
| 18. MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |                                  |
| Immediate cause (a) <u>Arteriosclerotic cardiovascular disease</u><br>Antecedent cause(s) (b) <u>Diabetes mellitus</u><br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>240X</u> |  |                                  |

|  |   |   |
|--|---|---|
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes mellitus</u> |   |   |
| 19a. DATE OF OPERATION   | 19b. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.   | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY                                 | (CITY OR TOWN) (COUNTY) (STATE)   |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | HOW DID INJURY OCCUR?   |

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE H. Z. L. (Degree or title) Chief Medical Examiner ADDRESS 700 Fleet Street DATE SIGNED Aug. 1, 1955

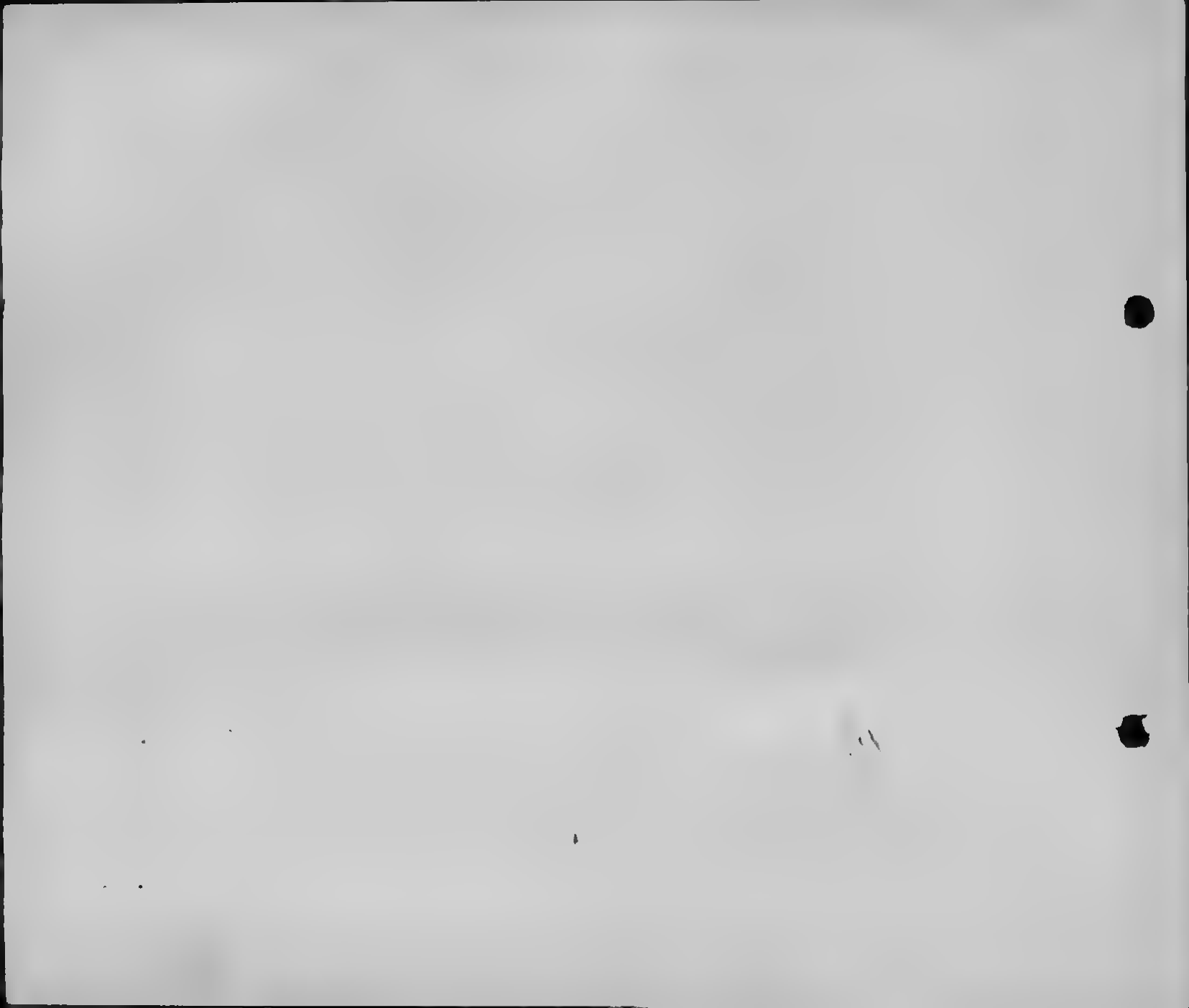
|   |                       |                               |                                  |         |
|---|-----------------------|-------------------------------|----------------------------------|---------|
| 23. BURIAL, CREMATION OR DISPOSAL (Specify) | DATE THEREOF          | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| <u>Burial</u>                               | <u>Aug. 3/55</u>      | <u>Harold Ridge</u>           | <u>Cokesville, Md.</u>           |         |
| DATE RECD BY LOCAL REG.                     | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR          | ADDRESS                          |         |
| <u>P. 3-55</u>                              | <u>R. H. Neslund</u>  | <u>Harry H. Whitte</u>        | <u>4101 Edmondson</u>            |         |

MARGIN RESERVED FOR BINDING

USE WRITING PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

ah

VS. ALSO



6372

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                   |   |                    |  |                 |  |                  |
|--|-------------------|---|--------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH:   |                   |   |                    | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                 |  |                  |
| COUNTY <u>Balto</u>  |                   | MARYLAND  |                    | STATE <u>Md</u>  |                 | COUNTY <u>Balto</u>                        |                  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN   |                   | LENGTH OF STAY (in this place)  |                    | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN |                 | 54   |                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                   | <u>Carroll Nursing Home</u>   |                    | STREET ADDRESS (If rural give location)  |                 | <u>523 S Marilyn Ave</u>                   |                  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |                   |   |                    | 4. DATE OF DEATH: (Month) (Day) (Year)   |                 |  |                  |
| <u>William R McNeil</u>  |                   |   |                    | <u>July 3 1955</u>   |                 |  |                  |
| 5. SEX:  | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):   | 8. DATE OF BIRTH:  | 9. AGE last birthday:  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |
| <u>Male</u>  | <u>White</u>      | <u>widow</u>  | <u>Nov 27 1879</u> | <u>75</u> yrs.   | Months          | Days                                       | Hours Min.       |
| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:   |                   |   |                    | 10b. KIND OF BUSINESS OR INDUSTRY:   |                 | 11. BIRTHPLACE (State or foreign country): |                  |
| <u>Post Office Ret</u>   |                   |   |                    | <u>Pa</u>  |                 | 12. CITIZEN OF WHAT COUNTRY?               |                  |
| 13. FATHER'S NAME:   |                   |   |                    | 14. MOTHER'S MAIDEN NAME:  |                 |  |                  |
| <u>Wm McNeil</u>   |                   |   |                    | <u>Don't Know</u>  |                 |  |                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |                   |   |                    | 16. SOCIAL SECURITY No.:   |                 | 17. INFORMANT & ADDRESS:                   |                  |
|  |                   |   |                    |  |                 | <u>Wm McNeil Jr 523 Marilyn Ave</u>        |                  |
| 18. MEDICAL CERTIFICATION  |                   |   |                    |  |                 |  |                  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                   |   |                    |  |                 | Interval Between Onset And Death           |                  |
| Immediate cause (a) <u>Coronary Insufficiency</u>  |                   |   |                    |  |                 | <u>3 days</u>                              |                  |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arteriosclerosis Ht. Dis</u>  |                   |   |                    |  |                 | <u>8 yrs</u>                               |                  |
| (c) <u>Generalized arteriosclerosis</u>  |                   |   |                    |  |                 | <u>8 yrs</u>                               |                  |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.   |                   |   |                    |  |                 |  |                  |
| 19a. DATE OF OPERATION:  |                   |   |                    | 19b. MAJOR FINDINGS OF OPERATION   |                 |  |                  |
|  |                   |   |                    |  |                 |  |                  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  |                   | PLACE (Home, farm, factory, street, office bldg., etc.)   |                    | (CITY OR TOWN)   |                 | (COUNTY) (STATE)                           |                  |
|  |                   | OF INJURY   |                    |  |                 |  |                  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |                   | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                    | HOW DID INJURY OCCUR?  |                 |  |                  |
|  |                   |   |                    |  |                 |  |                  |
| 22. I hereby certify that I attended the deceased from <u>May 30, 1955</u> , to <u>July 3, 1955</u> , that I last saw the deceased alive on <u>July 3, 1955</u> , and that death occurred at <u>630 AM</u> from the causes and on the date stated above. |                   |   |                    |  |                 |  |                  |
| SIGNATURE <u>James E. Means</u> (Degree or title) <u>M.D.</u>  |                   |   |                    | ADDRESS <u>520 D. St. Balto 19</u>   |                 | DATE SIGNED <u>7/3/55</u>                  |                  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)   |                   | DATE THEREOF  |                    | NAME OF CEMETERY OR CREMATORY  |                 | LOCATION (City, town, or county) (State)   |                  |
| <u>Removal</u>   |                   | <u>July 4/55</u>  |                    | <u>Huntington Conn</u>   |                 | <u>Huntington Pa</u>                       |                  |
| DATE REC'D BY LOCAL REGISTRAR  |                   | REGISTRAR'S SIGNATURE   |                    | 24. FUNERAL DIRECTOR   |                 | ADDRESS                                    |                  |
| <u>July 5, 1955</u>  |                   | <u>Mrs. Edith Hurley</u>  |                    | <u>Willis Funeral Home</u>   |                 | <u>2112 L. Carroll</u>                     |                  |

MARGIN RESERVED FOR BINDING

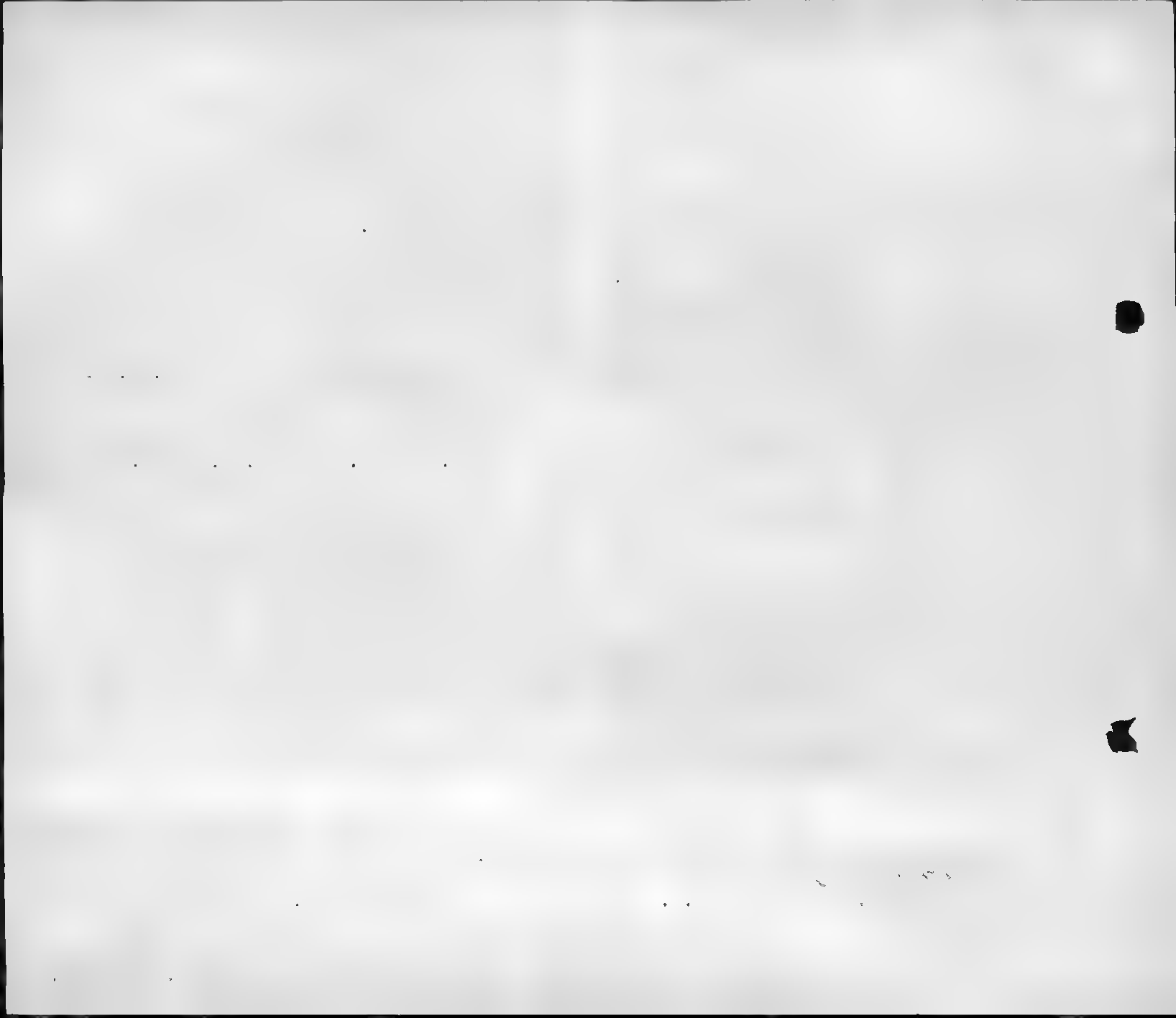
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. A. L. 1000



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| 6379 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06273   |                                |  |                     |
|--|--------------------------------|--|---------------------|
| Item 18 Film 6164 7-22-55  |                                |  |                     |
| CERTIFICATE OF DEATH   |                                |  |                     |
| Reg. Dist. No. <u>64</u>   |                                |  |                     |
| 1. PLACE OF DEATH  |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                     |
| COUNTY <b>BALTIMORE</b>  | MARYLAND                       | STATE <b>MARYLAND</b>  | COUNTY              |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR   | TOWN                |
| <b>PORT HOWARD</b>   | <b>27 DAYS</b>                 | <b>BALTIMORE</b>   |                     |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                                | STREET ADDRESS (If rural give location)  |                     |
| <b>VETERANS ADMINISTRATION HOSPITAL</b>  |                                | <b>15 W. BARNEY STREET</b>   |                     |
| 3. NAME OF DECEASED (Type or Print)  |                                | 4. DATE (Month) (Day) (Year) OF DEATH  |                     |
| First) <b>THOMAS</b>   | (Middle) <b>B.</b>             | (Last) <b>MEDICUS</b>  | <b>JULY 4 19 55</b> |
| 5 SEX  | 6 COLOR OR RACE                | 7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)  | 8 DATE OF BIRTH     |
| <b>MALE</b>  | <b>WHITE</b>                   | <b>MARRIED</b>   | <b>9/18/87</b>      |
| 9. AGE (last birthday)   |                                | 10. AGE (last birthday)  |                     |
| <b>67</b> yrs  |                                | <b>67</b> yrs  |                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                | 10B. KIND OF BUSINESS OR INDUSTRY  |                     |
| <b>WATCHMAN</b>  |                                | <b>OIL COMPANY</b>   |                     |
| 11. BIRTHPLACE (State or foreign country)  |                                | 12. CITIZEN OF WHAT COUNTRY?   |                     |
| <b>BALTIMORE, MARYLAND</b>   |                                | <b>U. S. A.</b>  |                     |
| 13. FATHER'S NAME  |                                | 14. MOTHER'S MAIDEN NAME   |                     |
| <b>FRANK MEDICUS</b>   |                                | <b>MARGARET MN: UNKNOWN</b>  |                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes give year or dates of service)  |                                | 16. SOCIAL SECURITY NO.  |                     |
| <b>YES</b>   |                                | <b>214-01-9250</b>   |                     |
| 17. INFORMANT & ADDRESS  |                                | 18. MEDICAL CERTIFICATION  |                     |
| <b>CLIN.REC.VET.ADM.HOSP.FT.HOWARD, MARYLAND</b>   |                                | 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                     |
|  |                                | IMMEDIATE CAUSE  |                     |
|  |                                | (A) <b>ASPHYXIA</b>  |                     |
|  |                                | DUE TO   |                     |
|  |                                | <b>ASPIRATION OF VOMITUS (not accidental)</b>  |                     |
|  |                                | (B)  |                     |
|  |                                | DUE TO   |                     |
|  |                                | (C)  |                     |
| 19. DATE OF OPERATION  |                                | 19B. MAJOR FINDINGS OF OPERATION   |                     |
|  |                                | <b>HUGE GASTRIC ULCER</b>  |                     |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                | 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH                                     |                     |
|  |                                |  |                     |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)  |                     |
|  |                                | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |                     |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                     |
|  |                                | 21F. HOW DID INJURY OCCUR?   |                     |
|  |                                |  |                     |
| 22. I hereby certify that I attended the deceased from <b>JUNE 7, 1955</b> to <b>JULY 4, 1955</b> , and that death occurred at <b>12:10 M.</b> from the causes and on the date stated above. |                                |  |                     |
| SIGNATURE  |                                | DATE SIGNED  |                     |
| <b>WILLIAM B. VANDEGRIFT, M.D.</b>   |                                | <b>7-5-55</b>  |                     |
| 23. BURIAL, CREMATION, REMOVAL (Specify)   |                                | NAME OF CEMETERY OR CREMATORY  |                     |
| <b>BURIAL</b>  |                                | <b>CEDAR HILL CEMETERY</b>   |                     |
| DATE THEREOF   |                                | LOCATION (City, town, or county) (State)   |                     |
| <b>7/8/55</b>  |                                | <b>BALTIMORE, MARYLAND</b>   |                     |
| DATE REC'D BY LOCAL REGISTRAR  |                                | 24. FUNERAL DIRECTOR   |                     |
| <b>7-6-55</b>  |                                | <b>MCCULLY FUNERAL HOME</b>  |                     |
| REGISTRAR'S SIGNATURE  |                                | ADDRESS  |                     |
|  |                                | <b>128 E. FORT AVE. BALTIMORE, MARYLAND</b>  |                     |



## CERTIFICATE OF DEATH

Reg. Dist. No. 3

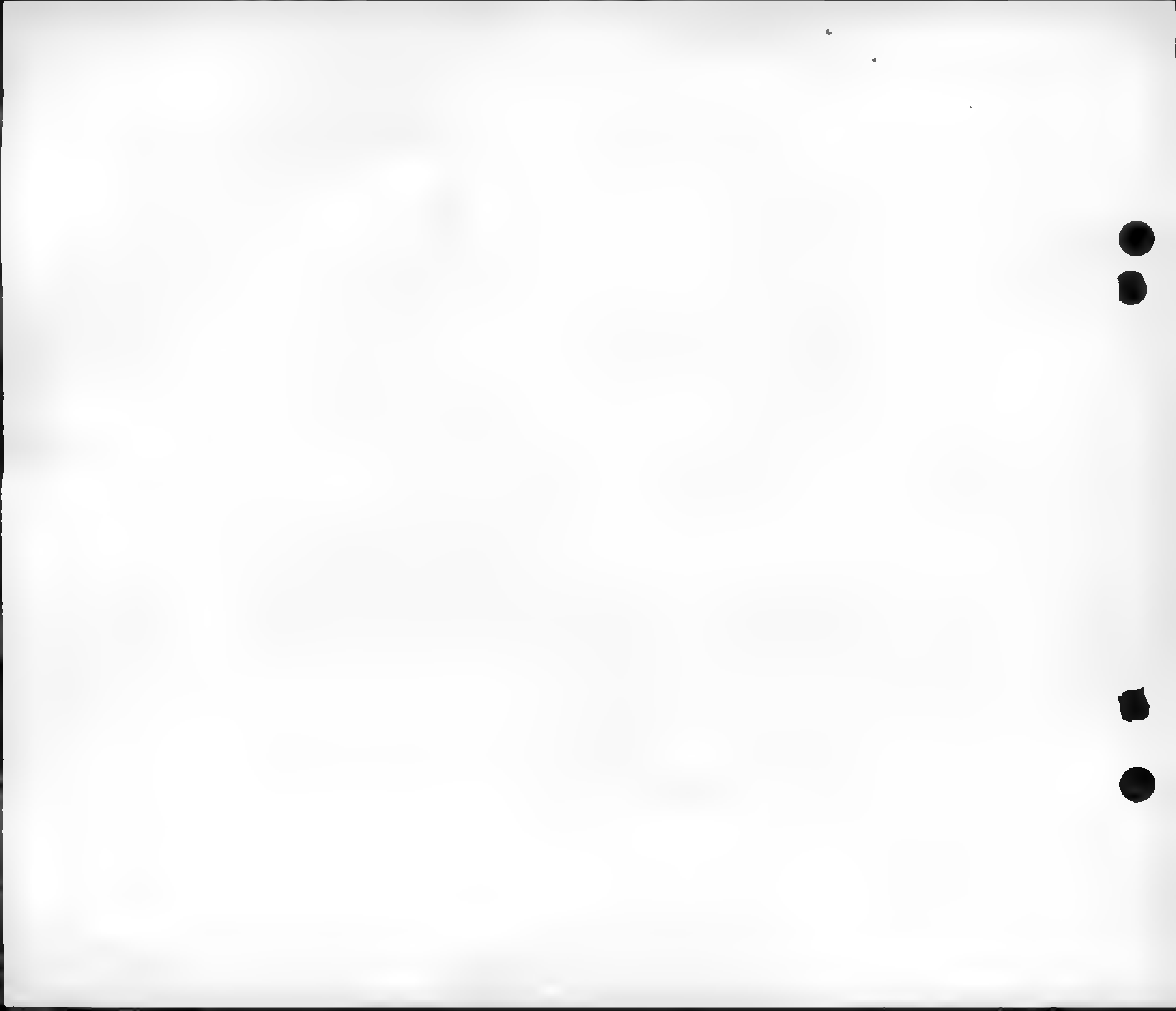
6374

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH:   |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                   |  |  |  |
| COUNTY <u>Baltimore</u>  |  | MARYLAND                                       |  | STATE <u>Maryland</u>  |  | COUNTY <u>AA</u>   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)  |  | LENGTH OF STAY (in this place)                 |  | CITY (If outside corporate limits, write RURAL and give nearest town)    |  |  |  |
| OR TOWN <u>Stoneleigh</u>  |  | <u>3 wks.</u>                                  |  | OR TOWN <u>Brooklyn Park 02-50-2</u>                                     |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>812 Regester Ave. Armacost Nursing Home</u>                         |  |  |  | STREET ADDRESS (If rural give location) <u>10 3rd Ave</u>                |  |  |  |
| 3. NAME OF DECEASED: (First) <u>Bertha</u> (Middle) <u>Mesecke</u> (Last) <u>Mesecke</u>                         |  |  |  | 4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>15</u> (Year) <u>1955</u> |  |  |  |
| 5. SEX: <u>Female</u>  |  | 6. COLOR OR RACE: <u>White</u>                 |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>         |  | 8. DATE OF BIRTH: <u>July 6, 1884</u>                    |  |
| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <u>Housewife</u>     |  | 10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u> |  | 11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>         |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>                 |  |
| 13. FATHER'S NAME: <u>Joseph Ellmer</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME: <u>Sarah Woodland</u>                          |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service) |  |  |  | 16. SOCIAL SECURITY NO.: <u>Wm. Mesecke</u>                              |  | 17. INFORMANT & ADDRESS: <u>10 3rd Ave Brooklyn Park</u> |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 18. MEDICAL CERTIFICATION  |  |   |  | Interval Between Onset And Death                                      |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |   |  |   |  |
| <u>420.1</u>   |  |   |  |   |  |
| Immediate cause (a) <u>Cerebral Occlusion</u>  |  |   |  |   |  |
| Antecedent causes (s) (b) <u>Arteriosclerosis Cardiovascular Disease</u>   |  |   |  |   |  |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)  |  |   |  |   |  |
| 11. OTHER SIGNIFICANT CONDITIONS   |  |   |  |   |  |
| Conditions contributing to the death but not related to the disease or condition causing death.  |  |   |  |   |  |
| 19a. DATE OF OPERATION:  |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  |  | PLACE (Home, farm, factory, street, office bldg., etc.)   |  | (CITY OR TOWN) (COUNTY) (STATE)                                       |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <u>1953</u> to <u>1955</u> , that I last saw the deceased alive on <u>6/24</u> , 19 <u>55</u> , and that death occurred at <u>7/15/55</u> , from the causes and on the date stated above. |  |   |  |   |  |
| SIGNATURE <u>Bertha Mesecke</u>  |  | (Degree or title)   |  | DATE SIGNED <u>July 19, 1955</u>                                      |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)   |  | DATE THEREOF  |  | NAME OF CEMETERY OR CREMATORY   |  |
| <u>Burial</u>  |  | <u>July 19, 1955</u>  |  | <u>Loudon Park</u>  |  |
| DATE RECD BY LOCAL REGISTRAR   |  | REGISTRAR'S SIGNATURE   |  | LOCATION (City, town, or county) (State)                              |  |
|  |  |   |  | <u>Balto. Md.</u>   |  |
| 24. FUNERAL DIRECTOR <u>Geo. J. Gonce</u> <u>4001 Ritchie Hwy Balto 25</u>   |  |   |  |   |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

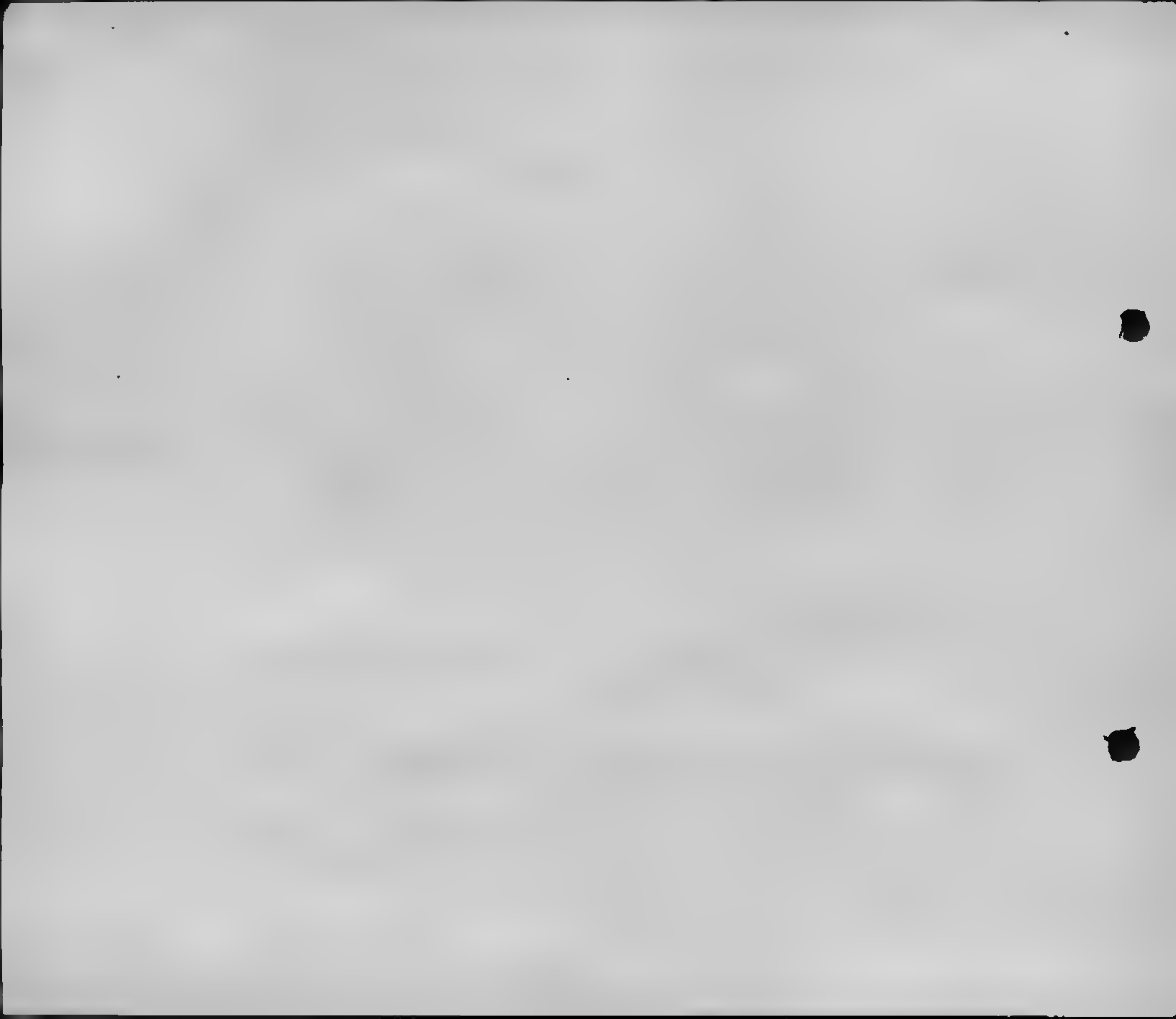


PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6375  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. ✓✓

Reg. Dist.

|  |                                |   |  |
|--|--------------------------------|---|--|
| 1. PLACE OF DEATH:   |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |  |
| COUNTY <u>Baltimore</u>  | MARYLAND                       | STATE <u>Maryland</u>   | COUNTY <u>Baltimore</u>                                |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br>X TOWN <u>Edgemere</u>   |                                | CITY (If outside corporate limits write RURAL and give nearest town)<br>TOWN <u>Edgemere-Baltimore, 19, Md.</u> X |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>At Home</u>  |                                | STREET ADDRESS (If rural, give location)<br><u>Maine Avenue Box 10</u>  |  |
| 3. NAME OF DECEASED:   |                                | 4. DATE OF DEATH  |  |
| (First) <u>Joseph</u>  | (Middle)                       | (Last) <u>Michalski</u>   | (Month) <u>July</u> (Day) <u>24</u> (Year) <u>1955</u> |
| 5. SEX: <u>Male</u>  | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Widowed</u>   | 8. DATE OF BIRTH: <u>5/19/1894</u>                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired</u>   |                                | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Nelson Corp.,</u>   | 9. AGE last birthday: <u>61</u> yrs                    |
| 11. FATHER'S NAME: <u>Stephen Michalski</u>  |                                | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |  |
| 13. MOTHER'S MAIDEN NAME: <u>Josephine Jankowski</u>   |                                | 14. INFORMANT & ADDRESS: <u>Baltimore 19, Md.</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |                                | 16. SOCIAL SECURITY No.: <u>218-14-9334</u>   |  |
| 17. MEDICAL CERTIFICATION  |                                | 18. MEDICAL CERTIFICATION   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |                                | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 4. Immediate cause (a) DUE TO <u>Coronary Occlusion</u>  |                                |   |  |
| Antecedent cause(s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)  |                                |   |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                |   |  |
| 19a. DATE OF OPERATION: <u>July 27, 1955</u>   |                                | 19b. MAJOR FINDING OF OPERATION:  |  |
| 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                                |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY  |  |
| 21c. (City or town) (County) (State)   |                                | 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  |
| 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                | 21f. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                |   |  |
| SIGNATURE <u>M. D. Davis</u>   |                                | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/25/55</u>  |  |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |                                | ASSISTANT MEDICAL EXAM. <input type="checkbox"/>  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>  |                                | DATE THEREOF: <u>July 27, 1955</u>  |  |
| NAME OF CEMETERY OR LOCATION: <u>Sacred Heart Of Mary</u>  |                                | LOCATION (City, town, or county) (State): <u>German hill Rd-Baltimore, Co.</u>                                    |  |
| DATE REC'D BY LOCAL REG. <u>7-26-55</u>  |                                | REGISTRAR'S SIGNATURE <u>George A. Weber</u>  |  |
| 24. GENERAL DIRECTOR <u>George A. Weber</u>  |                                | ADDRESS <u>705-8 Ave. St.</u>   |  |



6376

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1 PLACE OF DEATH

COUNTY BALTIMORE MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town)  
 TOWN FORT HOWARD LENGTH OF STAY (in this place) 9 DAYS

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS

VETERANS ADMINISTRATION HOSPITAL

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY SOMERSET  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN CRISFIELD 19-39-2

STREET ADDRESS (If rural give location)  
78 MARYLAND AVENUE

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

JOHN

W.

MILBOURNE

4. DATE (Month) (Day) (Year)

OF

DEATH: JULY 29

1955

## 5 SEX:

6 COLOR OR

7. SINGLE, MARRIED,

8. DATE OF BIRTH:

9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS

MALE

WHITE

WIDOWED DIVORCED,

2-27-87

68

yrs

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (State or foreign country): CRISFIELD, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

## 13. FATHER'S NAME:

SIDNEY F. MILBOURNE

## 14. MOTHER'S MAIDEN NAME:

LYDIA B. BELL

15 WAS DECEASED EVER IN U.S. ARMED FORCES?

YES

✓

(If Yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO.

214-18-4249

## 17. INFORMANT &amp; ADDRESS:

CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(A) ACUTE MYOCARDIAL INFARCTION  
 DUE TO ARTERIOSCLEROTIC HEART DISEASE

(B)  
 DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

RECENT

UNKNOWN

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JULY 20, 1955, to JULY 29, 1955, and that death occurred at 1:25 P.M. from the causes and on the date stated above.

SIGNATURE  
 FRANCIS G. DICKEY

ADDRESS  
 VAH, FORT HOWARD, MARYLAND

DATE SIGNED  
 7-29-55

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)  
 REMOVAL (SPECIFY) Aug. 1, 1955 SUNNYRIDGE CEMETERY CRISFIELD, MARYLAND

DATE REC'D BY LOCAL REGISTRAR

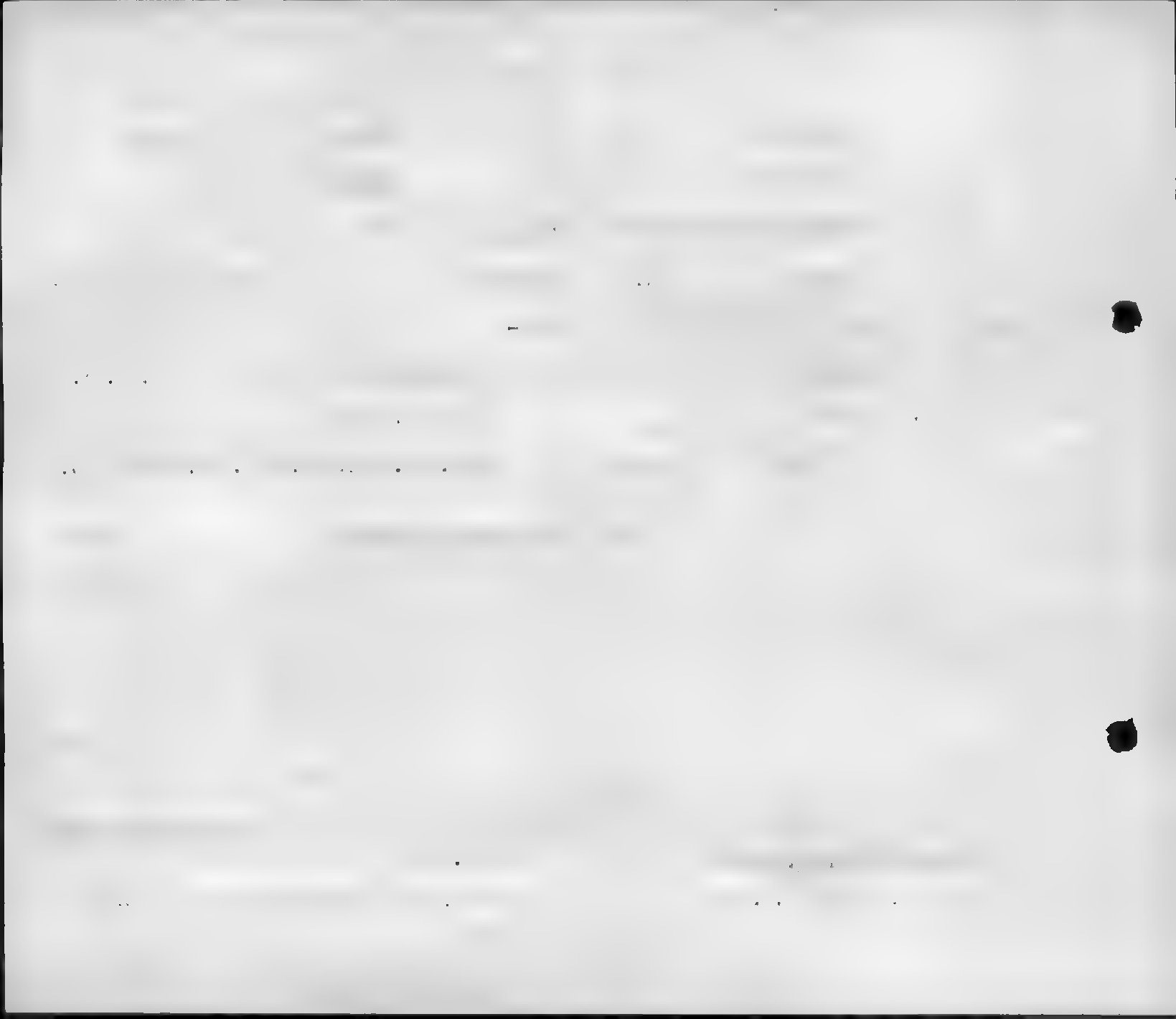
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR  
 BRADSHAW FUNERAL PARLOR  
 CRISFIELD, MARYLAND

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





6377

06377

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

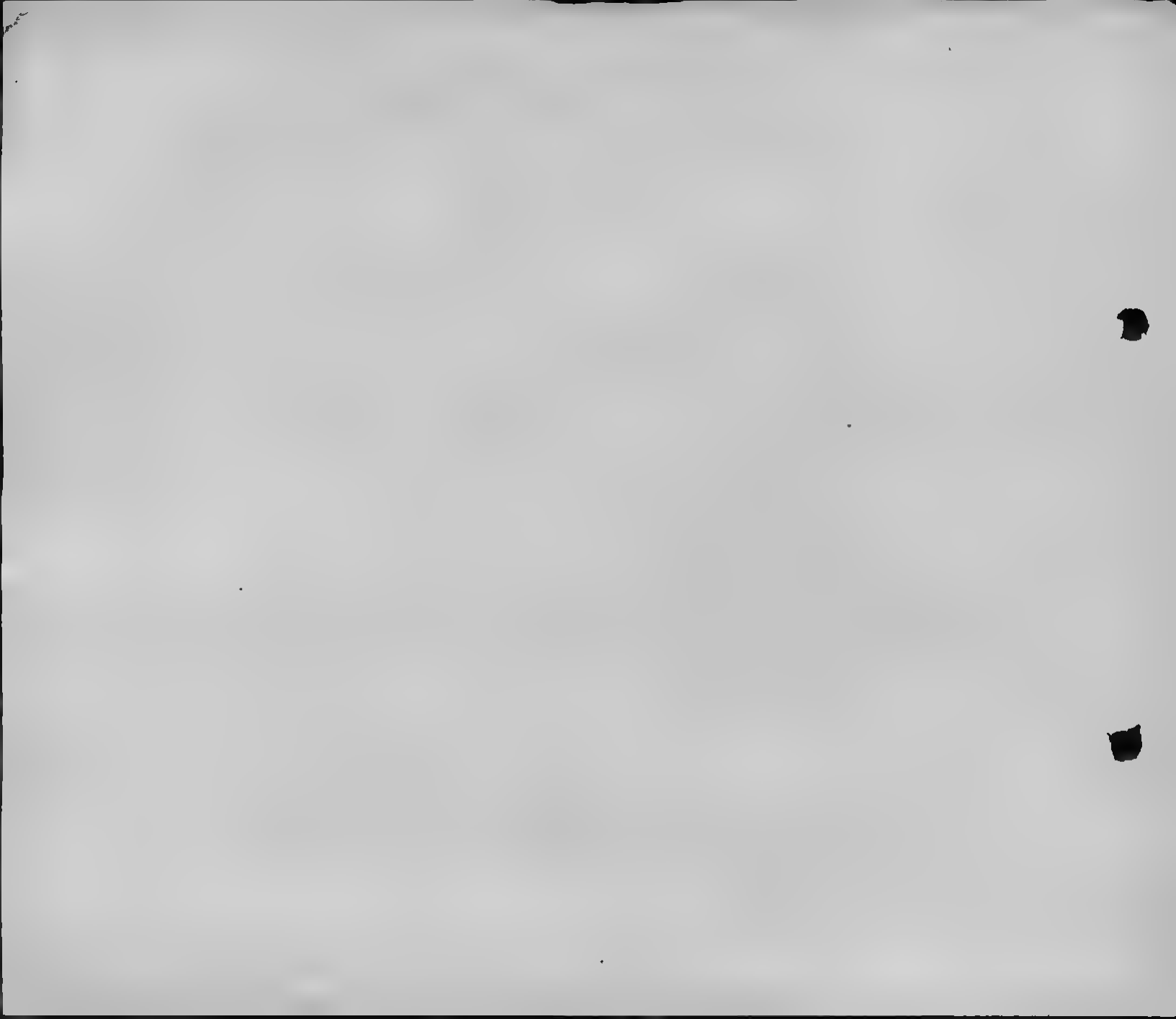
No. 21

|   |                   |   |                           |  |                                  |  |            |
|---|-------------------|---|---------------------------|--|----------------------------------|--|------------|
| 1. PLACE OF DEATH:  |                   |   |                           | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                                  |  |            |
| COUNTY Baltimore  |                   | MARYLAND  |                           | STATE Maryland   |                                  | COUNTY   |            |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  |                   | LENGTH OF STAY (In this place)  |                           | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore |                                  |  |            |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                   | Fort Miller Island Road   |                           | STREET ADDRESS (If rural, give location) 1822 Port Street                              |                                  |  |            |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |                   |   |                           | 4. DATE OF DEATH (Month) (Day) (Year)  |                                  |  |            |
| AUGUST GRIST MILLER, JR.  |                   |   |                           | July 7 19 55   |                                  |  |            |
| 5. SEX:   | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):   | 8. DATE OF BIRTH:         | 9. AGE last birthday:  | IF UNDER 1 YEAR IF UNDER 24 HRS. |  |            |
| Male  | White             | Single  | Sept 9 <sup>th</sup> 1921 | 33 yrs.  | Months                           | Days   | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):   |                   | 10b. KIND OF BUSINESS OR INDUSTRY:  |                           | 11. BIRTHPLACE (State or foreign country):   |                                  | 12. CITIZEN OF WHAT COUNTRY?   |            |
| Pump House for Chelity  |                   |   |                           | Md.  |                                  |  |            |
| 13. FATHER'S NAME:  |                   |   |                           | 14. MOTHER'S MAIDEN NAME:  |                                  |  |            |
| Aug Miller Sr   |                   |   |                           | Margaret Lezanicka   |                                  |  |            |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)  |                   | 16. SOCIAL SECURITY No.:  |                           | 17. INFORMANT & ADDRESS:   |                                  |  |            |
| (If Yes, give war or dates of service)  |                   |   |                           | Mrs Margaret Miller 1822 Port St   |                                  |  |            |
| 18. MEDICAL CERTIFICATION   |                   |   |                           |  |                                  |  |            |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  |                   |   |                           |  |                                  | INTERVAL BETWEEN ONSET AND DEATH   |            |
| 424.8<br>Immediate cause (a) Drowning<br>DUE TO   |                   |   |                           |  |                                  |  |            |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO   |                   |   |                           |  |                                  |  |            |
| stating underlying cause last (c)   |                   |   |                           |  |                                  |  |            |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Acute alcoholic intoxication  |                   |   |                           |  |                                  |  |            |
| 19a. DATE OF OPERATION:   |                   | 19b. MAJOR FINDING OF OPERATION:  |                           |  |                                  |  |            |
|   |                   |   |                           |  |                                  |  |            |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                   | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY  |                           | 21c. (City or town) (County) (State)   |                                  | 28. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |            |
|   |                   | water   |                           | Miller's Island Baltimore Md.  |                                  |  |            |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                   | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |                           | 21f. HOW DID INJURY OCCUR? Drowned in 5' water while intoxicated                       |                                  |  |            |
| July 7, 1955 2: M.  |                   |   |                           |  |                                  |  |            |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                   |   |                           |  |                                  |  |            |
| SIGNATURE   |                   | DATE SIGNED   |                           | CHIEF MEDICAL EXAMINER   |                                  |  |            |
| R. F. Fisher  |                   | 7/7/55  |                           | DEPUTY MEDICAL EXAMINER  |                                  |  |            |
|   |                   |   |                           | M. D. ASSISTANT MEDICAL EXAM.  |                                  |  |            |
| 23. BURIAL, CREMATION, REMOVAL (Specify):   |                   | DATE THEREOF  |                           | NAME OF CEMETERY OR CREMATORY  |                                  | LOCATION (City, town or county) (State)  |            |
| Burial  |                   | July 11 <sup>th</sup> 1955  |                           | Swartz   |                                  | Chonell St. Est  |            |
| DATE REC'D BY LOCAL REG.  |                   | REGISTERAR'S SIGNATURE  |                           | FUNERAL DIRECTOR   |                                  | ADDRESS  |            |
| 7-8-55  |                   | R. W. Hedrick   |                           | Geo. B. Cook   |                                  | 1701-03 N. Patterson Park Ave  |            |

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



06378

## MARYLAND STATE DEPARTMENT OF HEALTH

6378

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 3

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>COUNTY <b>Balto.</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <b>Md.</b> COUNTY <b>Balto</b>   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>Parkville</b>   |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>Parkville</b>                               |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>8721 Baker Ave.</b>   |                                  | STREET ADDRESS (If rural, give location)<br><b>8721 Baker Ave.</b>  |  |
| 3. NAME OF DECEASED<br>(Type or Print) <b>Katherine Elmore Miller</b>   |                                  | 4. DATE OF DEATH<br>(Month) <b>July</b> (Day) <b>25</b> (Year) <b>1945</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>   | 8. DATE OF BIRTH<br><b>Jan. 2, 1883</b>                      |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 9b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE last birthday<br><b>72</b> yrs.                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |
| 13. FATHER'S NAME<br><b>William Loose</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Louisa Hamp</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                                  | 16. SOCIAL SECURITY No.   |  |
| 17. INFORMANT AND ADDRESS<br><b>Mr. George M. Miller 8721 Baker Ave.</b>  |                                  | 18. MEDICAL CERTIFICATION   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                  |   | INTERVAL BETWEEN ONSET AND DEATH                             |
| Immediate cause (a) <b>Coronary Occlusion</b>   |                                  |   | <b>Sudden</b>  |
| Antecedent cause(s) (b) <b>Hyper-tension, Cardiac Renal</b>   |                                  |   |  |
| (c) <b>Vascular Disease</b>   |                                  |   | <b>5 yrs.</b>  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |                                  |   |  |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY?  |                                  |   |  |
| Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |                                  |   |  |
| 21. FINAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH  |                                  | PLACE (Home, farm, factory, street, or office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)                              |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by Autopsy, Inspection or Inquiry, and that the deceased died on the day stated above, and death in my opinion resulted from natural causes, <b>accident</b> , suicide, homicide, undetermined. |                                  |   |  |
| SIGNATURE<br><b>W. H. O'Donnell M.D.</b>  |                                  | DATE SIGNED<br><b>7/26/55</b>   |  |
| LOCATION (City, town, or county) (State)  |                                  | NAME OF CEMETERY OR CREMATORY   |  |
| 7/26/55   |                                  | St. Paul's Cemetery, Baltimore  |  |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE   |                                  | 23. FUNERAL DIRECTOR'S ADDRESS  |  |
| 7/26/55   |                                  | Wm. J. Lickner & Sons, Inc.   |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE UNIVERSITY OF CHICAGO  
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MARYLAND

6379

06379  
STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Items 13, 14 Film 6184 7-18-55 et

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>COUNTY <u>AA</u> MARYLAND   |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Md.</u> COUNTY <u>AA</u>                                     |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>X</u> TOWN <u>Washington</u>   |                               | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>X</u>                      |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Local Road</u>  |                               | STREET ADDRESS (If rural, give location) <u>Local Road</u>   |  |
| 3. NAME OF DECEASED<br>(First) <u>LOA</u> (Middle) <u>KEY</u> (Last) <u>MILLER</u>   |                               | 4. DATE OF DEATH<br>(Month) <u>12</u> (Day) <u>18</u> (Year) <u>1955</u>                                       |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED; (Specify) <u>Married</u>  | 8. DATE OF BIRTH <u>March 11, 1913</u> |
| 9. AGE last birthday <u>42</u> yrs.  |                               | 10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Unknown</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT AND ADDRESS <u>Local Road</u>  |                               | 18. MEDICAL CERTIFICATION  |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><u>434.1</u><br>Immediate cause (a) <u>Cerebral Thrombosis</u><br>Antecedent cause(s) (b) <u>Con. Thrombosis</u><br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Unknown</u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>1</u>  |  |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |                               | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| 19a. DATE OF OPERATION   |                               | 19b. MAJOR FINDINGS OF OPERATION   |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  |                               | PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)                     |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |                               | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>              |  |
| HOW DID INJURY OCCUR?  |                               |  |  |
| 22. I hereby certify that I attended the deceased from <u>March 11, 1913</u> , to <u>December 18, 1955</u> , that I last saw the deceased alive on <u>July 1, 1955</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.                          |                               |  |  |
| SIGNATURE <u>A. Hedrich</u> (Degree or title)  |                               | ADDRESS <u>St. Paul St.</u> DATE SIGNED <u>7/15/55</u>   |  |
| 23. BURIAL, CREMATION, OR OTHER DISPOSAL <u>Burial</u>   |                               | NAME OF CEMETERY OR CREMATORIUM <u>St. Paul St.</u> LOCATION (City, town, or county) (State) <u>Washington</u> |  |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>7-13-55</u> <u>A. Hedrich</u>   |                               | 24. FUNERAL DIRECTOR <u>St. Paul St.</u> ADDRESS <u>St. Paul St.</u>   |  |

dmr.

MARGIN RESERVED FOR BINDING



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07457

Item 8, Filing 187, 9-28-55 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

|   |                            |   |  |
|---|----------------------------|---|--|
| 1. PLACE OF DEATH<br>COUNTY <u>Baltimore</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>Granite</u><br>TOWN <u>Granite</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>   |                            | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>MD.</u> COUNTY <u>Baltimore</u><br>CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Granite</u><br>STREET ADDRESS (If rural give location) <u>St Paul Ave.</u> |  |
| 3. NAME OF DECEASED:<br>(First) <u>Mary</u> (Middle) <u>Frances</u> (Last) <u>Miller</u>  |                            | 4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>22</u> (Year) <u>1955</u>  |  |
| 5. SEX: <u>Sp.</u>  | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed Aug 7, 1958</u>   | 8. DATE OF BIRTH: <u>1958</u> 9. AGE last birthday <u>96</u> yrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>   |                            | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country): <u>MD.</u>   |                            | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>  |  |
| 13. FATHER'S NAME: <u>? — Bodka</u>   |                            | 14. MOTHER'S MAIDEN NAME: <u>? — Gallagher</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>-</u>  |                            | 16. SOCIAL SECURITY NO. <u>None</u>   |  |
| 17. INFORMANT & ADDRESS: <u>Francis X Miller - Granite, Md.</u>   |                            |   |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br>421.1<br>IMMEDIATE CAUSE<br>ANTECEDENT CAUSE (S)<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.<br>(A) <u>Coronary occlusion</u><br>DUE TO<br>(B) <u>Cardio-vascular disease</u><br>DUE TO<br>(C)         |                            | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr</u>   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                            |   |  |
| 19A. DATE OF OPERATION:   |                            | 19B. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                            | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)  |  |
| 21C. WHERE DID (City or town) (County) (State)  |                            | 21F. HOW DID INJURY OCCUR?  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                            | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |
| 22. I hereby certify that I attended the deceased from ..... 1944 to 7/22/1955 that I last saw the deceased alive on 7/24, 1955, and that death occurred at 6:30 P.M. from the causes and on the date stated above.<br>SIGNATURE <u>Tom E. Martin</u> ADDRESS <u>M. D. Randalltown</u> DATE SIGNED <u>7/23/55</u> |                            |   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |                            | DATE THEREOF <u>7-26-55</u>   |  |
| NAME OF CEMETERY OR CREMATORY <u>St Alphonsus</u>   |                            | LOCATION (City, town, or county) (State) <u>Woodstock Md.</u>   |  |
| DATE REC'D BY LOCAL REGISTRAR <u>7/23/55</u>  |                            | REGISTRAR'S SIGNATURE <u>Tom E. Martin</u>  |  |
| FUNERAL DIRECTOR <u>Arthur H. Haight - Alpha, Md.</u>   |                            | ADDRESS   |  |

RECEIVED  
JAN 11 1964

ALB

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information accurately. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6381

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

|   |                            |   |  |   |  |  |  |
|---|----------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH:  |                            |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |  |  |  |
| COUNTY <u>Baltimore</u>   |                            | MARYLAND  |  | STATE <u>md.</u>  |  | COUNTY <u>An.</u>  |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  |                            | LENGTH OF STAY (in this place)  |  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN |  | STREET ADDRESS   |  |
| X <u>OR TOWN</u> <u>Orange Mills</u>  |                            | <u>100 days</u>   |  | <u>Clear Spring, md.</u>  |  | <u>21X-2</u>   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                            |   |  | STREET ADDRESS  |  |  |  |
| <u>Rosewood State Training School</u>   |                            |   |  | <u>Route # 2</u>  |  |  |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |                            |   |  | 4. DATE OF DEATH: (Month) (Day) (Year)  |  |  |  |
| <u>MR DEBRA KAY MILLS</u>   |                            |   |  | <u>7 30 19 55</u>   |  |  |  |
| 5. SEX: <u>F</u>  | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>  | 8. DATE OF BIRTH: <u>3/22/55</u>                                       | 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS                         |  |  |  |
|   |                            |   | yrs. <u>4</u> Months <u>8</u> Days <u>8</u> Hours <u></u> Min. <u></u> |   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>  |                            | 10b. KIND OF BUSINESS OR INDUSTRY:  |  | 11. BIRTHPLACE (State or foreign country): <u>md.</u>                         |  | 12. CITIZEN OF WHAT COUNTRY? <u>us.</u>                          |  |
| 13. FATHER'S NAME: <u>unknown</u>   |                            |   |  | 14. MOTHER'S MAIDEN NAME: <u>CARRIE MAE MILLS</u>                             |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>   |                            | 16. SOCIAL SECURITY No.:  |  | 17. INFORMANT & ADDRESS: <u>Hospital Records.</u>                             |  |  |  |
|   |                            |   |  |   |  |  |  |
| 18. MEDICAL CERTIFICATION   |                            |   |  |   |  |  |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  |                            |   |  |   |  |  |  |
| 752X Immediate cause  |                            | (a) DUE TO  |  | Bronchopneumonia; generalized toxemia   |  |  |  |
| Antecedent cause(s)   |                            | (b) DUE TO  |  | Meningococci, hydrocephalus   |  |  |  |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last  |                            | (c)   |  | from birth  |  |  |  |
| 2. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.  |                            |   |  |   |  |  |  |
| 19a. DATE OF OPERATION: <u>7/21/55</u>  |                            |   |  | 19b. MAJOR FINDINGS OF OPERATION: <u>Ventriculo peritoneal shunt</u>          |  |  |  |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>   |                            |   |  |   |  |  |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)   |                            | PLACE (Home, farm, factory, street, or office bldg., etc.)  |  | (CITY OR TOWN)  |  | (COUNTY) (STATE)   |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |                            | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?   |  |  |  |
| M.  |                            |   |  |   |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>4/19</u> , 19 <u>55</u> , to <u>7/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/30</u> , 19 <u>55</u> , and that death occurred at <u>4 a.m.</u> , from the causes and on the date stated above. |                            |   |  |   |  |  |  |
| SIGNATURE <u>David J. Nail</u>  |                            |   |  | (DEGREE OR TITLE) <u>md. Clinical Director</u>                                |  | DATE SIGNED <u>7/30/55</u>                                       |  |
| 23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>  |                            | DATE THEREOF <u>8/1/55</u>  |  | NAME OF CEMETERY OR CREMATORY <u>St. Pauls</u>                                |  | LOCATION (City, town, or county) (State) <u>Clear Spring md.</u> |  |
| DATE REC'D BY LOCAL REG. <u>7-31-55</u>   |                            | REGISTRAR'S SIGNATURE <u>Mary B. Zline</u>  |  | 24. FUNERAL DIRECTOR <u>Adrian H. Rowland</u>                                 |  | ADDRESS <u>Clear Spring md.</u>                                  |  |

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MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>COUNTY <u>BALTO.</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>MD</u> COUNTY <u>BALTO</u>                                     |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>SH PAVEMENT AT</u> LENGTH OF STAY (in this place) <u>ONE</u> |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>BALTIMORE (22)</u>           |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CENTRAL + ST. HELENA AVE.</u>  |                                  | STREET ADDRESS (If rural, give location)<br><u>6562 PARNELL AVE.</u>   |   |
| 3. NAME OF DECEASED (First) (Middle) (Last)<br><u>MAJOR</u> <u>(NMI.)</u> <u>MITCHELL</u>   |                                  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>7-5-</u> <u>1955</u>   |   |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>SINGLE</u>   | 8. DATE OF BIRTH<br><u>DEC 31, 1884</u> |
| 9. AGE last birthday<br><u>70</u> yrs.  |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>CO. 30 PMAN</u> |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>N.C.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>(UNKNOWN)</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>MARGARET (?)</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>                         |                                  | 16. SOCIAL SECURITY No.<br><u>213-01-3445</u>  |   |
| 17. INFORMANT<br><u>M.S. MCMAHON</u>  |                                  | 18. ADDRESS<br><u>6571 ST. HELENA AVE.</u><br><u>BALTO. 22, MD.</u>  |   |

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

353.3

Immediate cause

(a)

Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Epilepsy -

(c)

INTERVAL BETWEEN ONSET AND DEATH

Immediate  
Dec 15, 50.

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF DEATH July 5 1955 7:30 AMINJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W. McNamee M.D.Balto. Co. Sandalk 22 July 5 1955

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BURIAL7-7-55SAK LAWNBALTO. CO. MD.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

July 5-1955 William M Kelly1414 1/2 Bldg, Sandalk, Md

MARGIN RESERVED FOR BINNING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6388

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                |  |                                  |
|---|--------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH   |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                                  |
| COUNTY <u>BALTO.</u>  | MARYLAND                       | STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>   |                                  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>RURAL - RANCHLEIGH</u>  | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>RURAL - RANCHLEIGH</u> | X                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>6611 EDEN VALE RD</u>   |                                | STREET ADDRESS (If rural give location)<br><u>6611 EDEN VALE RD.</u>                                       |                                  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><u>KATIE</u> <u>MOGOL</u>   |                                | 4. DATE (Month) (Day) (Year)<br>OF DEATH: <u>7 - 12</u> 19 <u>55</u>                                       |                                  |
| 5. SEX: <u>FEMALE</u>   | 6. COLOR OR RACE: <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>   | 8. DATE OF BIRTH: <u>1884</u>    |
| 9. AGE last birthday: <u>76</u> yrs.  |                                | 10. AGE last birthday: IF UNDER 1 YEAR: Months Days Hours Min.   |                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NONE</u>  |                                | 10B. KIND OF BUSINESS OR INDUSTRY:   |                                  |
| 11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MD</u>   |                                | 12. CITIZEN OF WHAT COUNTRY?   |                                  |
| 13. FATHER'S NAME: <u>NATHAN SMITH</u>  |                                | 14. MOTHER'S MAIDEN NAME: <u>REBECCA</u>   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |                                | 16. SOCIAL SECURITY NO.  |                                  |
| 17. INFORMANT & ADDRESS: <u>FRANK MOGOL - SAME</u>  |                                |  |                                  |
| 18. MEDICAL CERTIFICATION   |                                |  | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                |  |                                  |
| 260X IMMEDIATE CAUSE (A) <u>Cardiac Failure, chronic</u>  |                                |  | <u>2 years</u>                   |
| ANTECEDENT CAUSE (B) <u>Arteriosclerosis, Hypertension, Rheumatic CV</u>  |                                |  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes, Mellitus</u>   |                                |  |                                  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Asthma, Peptic Ulcer</u>  |                                |  |                                  |
| 19A. DATE OF OPERATION:   |                                | 19B. MAJOR FINDINGS OF OPERATION   |                                  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                |  |                                  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                     |                                  |
| 21C. WHERE DID (City or town) (County) (State)  |                                | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                                | 21F. HOW DID INJURY OCCUR?   |                                  |
| 22. I hereby certify that I attended the deceased from .. 19 <u>48</u> to <u>7/12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/10/55</u> and that death occurred at <u>6:15</u> M, from the causes and on the date stated above. |                                |  |                                  |
| SIGNATURE <u>S. D. Lisanti</u>  |                                | ADDRESS <u>3210 Edinboro Ave</u> DATE SIGNED <u>7/18/55</u>  |                                  |
| M. D. <u>3210 Edinboro Ave</u>  |                                |  |                                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>  |                                | DATE THEREOF <u>7-14-1955</u>  |                                  |
| NAME OF CEMETERY OR CREMATORY <u>ARLINGTON</u>  |                                | LOCATION (City, town, or county) (State) <u>BALTO. MD</u>  |                                  |
| DATE REC'D BY LOCAL REGISTRAR <u>7-14-55</u>  |                                | REGISTRAR'S SIGNATURE <u>John Lewis Inc - 2100 Eutaw Place</u>   |                                  |
| 24. FUNERAL DIRECTOR  |                                | ADDRESS  |                                  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

118  
2710  
- 118  
118

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Reg. Dist. No. 51

6334

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>COUNTY <u>BALTIMORE</u>   |  | MARYLAND   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>MARYLAND</u>                                     |  | COUNTY <u>BALTIMORE</u>  |  |
| CITY (If outside corporate limits, write RURAL and OR give nearest town)<br>X TOWN <u>LOCHERN</u>              |  | LENGTH OF STAY<br>(In this place)<br><u>14 YEARS</u> |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <u>LOCHERN</u> |  | X  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br>TO <u>6419 Liberty Road</u>                                       |  |  |  | STREET ADDRESS<br><u>6419 Liberty Road</u>   |  | (If rural, give location)  |  |
| 3. NAME OF DECEASED<br>(Type or Print)   |  | (First)  |  | (Middle)   |  | (Last)   |  |
| <u>Anna</u>  |  | <u>Robinson</u>                                      |  | <u>Molloy</u>  |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>July 7 1953</u>     |  |
| 5. SEX<br><u>FEMALE</u>  |  | 6. COLOR OR RACE<br><u>WHITE</u>                     |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>                                    |  | 8. DATE OF BIRTH<br><u>10-6-86</u>                                 |  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u> |  | 9b. KIND OF BUSINESS OR INDUSTRY<br><u>DOMESTIC</u>  |  | 9. AGE last birthday<br><u>68 yrs.</u>   |  | 10. If under 1 year 1 year 1 year 1 year<br>Months Days Hours Min. |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>   |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>         |  | 13. FATHER'S NAME<br><u>WILLIAM R. FOLTZ</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>ANNA B. EISENHART</u>               |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>                                    |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>               |  | 17. INFORMANT AND ADDRESS<br><u>LAURENCE P. MOLLOY 6419 Liberty Rd</u>                             |  |  |  |

|   |  |           |  |   |  |  |  |                       |  |                           |  |  |  |
|---|--|-----------|--|---|--|--|--|-----------------------|--|---------------------------|--|--|--|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |           |  |   |  |  |  |                       |  | 18. MEDICAL CERTIFICATION |  | INTERVAL BETWEEN ONSET AND DEATH                         |  |
| Immediate cause (a) <u>Cerebral aneurysm</u><br>Antecedent cause(s) (b) <u>Mitral in the Brain &amp; Chest</u><br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Cor. of Left Breast 7 years ago</u> |  |           |  |   |  |  |  |                       |  |                           |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS  |  |           |  |   |  |  |  |                       |  |                           |  |  |  |
| Conditions contributing to the death but not related to the disease or condition causing death.   |  |           |  |   |  |  |  |                       |  |                           |  |  |  |
| 19a. DATE OF OPERATION  |  |           |  | 19b. MAJOR FINDINGS OF OPERATION  |  |  |  |                       |  |                           |  | 20. AUTOPSY?   |  |
|   |  |           |  |   |  |  |  |                       |  |                           |  | Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| 21. ACCIDENT SUICIDE HOMICIDE   |  | (Specify) |  | PLACE (Home, farm, factory, street, OF office bldg., etc.)  |  |  |  | (CITY OR TOWN)        |  | (COUNTY)                  |  | (STATE)  |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | m.        |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  |  |  | HOW DID INJURY OCCUR? |  |                           |  |  |  |

22. I hereby certify that I attended the deceased from June, 1955 to 7-7, 1955, that I last saw the deceased alive on 7-6, 1955 and that death occurred at 2 A m., from the causes and on the date stated above.

|                    |                   |                  |               |
|--------------------|-------------------|------------------|---------------|
| SIGNATURE          | (Degree or title) | ADDRESS          | DATE SIGNED   |
| <u>[Signature]</u> |                   | <u>[Address]</u> | <u>[Date]</u> |

|   |                       |                               |                                  |         |
|---|-----------------------|-------------------------------|----------------------------------|---------|
| 23. BURIAL CREMATION<br>REMOVAL (Specify) | DATE                  | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| BURIAL                                    | 7-11-55               | LONDON PARK                   | BALTIMORE                        | MD      |
| DATE REC'D BY LOCAL<br>REG.               | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR          | ADDRESS                          |         |
| 7-1-55                                    | [Signature]           | George L. Schwab              | 2101 Frederick Ave               |         |

MARGIN RESERVED FOR BINDING

VS. A15

**PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.**





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6385

CERTIFICATE OF DEATH

Reg. Dist. No.

06284

|   |                                |  |                                       |
|---|--------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH:  |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                                       |
| COUNTY <b>Baltimore</b>   | MARYLAND                       | STATE <b>Maryland</b>  | COUNTY                                |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Towson</b>                      | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b> | 3014                                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>408 Oak Lane</b>   |                                | STREET ADDRESS (If rural give location) <b>3705 Old York Road</b>                              |                                       |
| 3. NAME OF DECEASED:  |                                | 4. DATE (Month) (Day) (Year)   |                                       |
| (First) <b>Mr. Charles</b>  | (Middle) <b>Edgar</b>          | (Last) <b>Moran</b>  | OF DEATH: <b>July 5, 1955</b>         |
| 5. SEX <b>male</b>  | 6. COLOR OR RACE <b>white</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>widowed</b>                               | 8. DATE OF BIRTH <b>June 14, 1878</b> |
| 9. AGE last birthday <b>77</b> yrs.   |                                | 10. AGE last birthday (If UNDER 1 YEAR Months Days Hours Min.)                                 |                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>at home</b> |                                | 10B. KIND OF BUSINESS OR INDUSTRY:   |                                       |
| 11. BIRTHPLACE (State or foreign country): <b>Baltimore, Maryland</b>                                       |                                | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                       |
| 13. FATHER'S NAME: <b>Mr. Richard T. Moran</b>  |                                | 14. MOTHER'S MAIDEN NAME: <b>Alice ?</b>   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)        |                                | 16. SOCIAL SECURITY NO.  |                                       |
| 17. INFORMANT & ADDRESS: <b>Mr</b>  |                                |  |                                       |

|   |  |                                  |
|---|--|----------------------------------|
| 18. MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |                                  |
| IMMEDIATE CAUSE (A) <b>420.1 Coronary artery occlusion</b>  |  | <b>12 hours</b>                  |
| ANTECEDENT CAUSE (B) DUE TO   |  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO              |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. |  |                                  |

|  |  |  |  |  |
|--|--|--|--|--|
| 19A. DATE OF OPERATION:  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                     |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |
| 22. I hereby certify that I attended the deceased from <b>Nov 1954</b> , to <b>July 5, 1955</b> , that I last saw the deceased alive on <b>11/15</b> , 1954, and that death occurred at <b>24</b> M, from the causes and on the date stated above. |  |  |  |  |
| SIGNATURE <b>Maddens C. Swinski</b>  |  | ADDRESS <b>M. D. 1700 Rome Ave. Towson</b>   |  | DATE SIGNED <b>July 5, 1955</b>  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | DATE THEREOF <b>July 8, 1955</b>   |  | NAME OF CEMETERY OR CREMATORY <b>Baltimore, Maryland</b>                         |
| DATE REC'D BY LOCAL REGISTRAR <b>July 5, 1955</b>  |  | REGISTRAR'S SIGNATURE <b>H. M. Hedrick</b>   |  | 24. FUNERAL DIRECTOR <b>Leonard J. Ruck, 5305 Harford Road #14</b>               |

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Thaddeus Siwinski  
17 W. Penna Avenue  
until 10:30A.N.

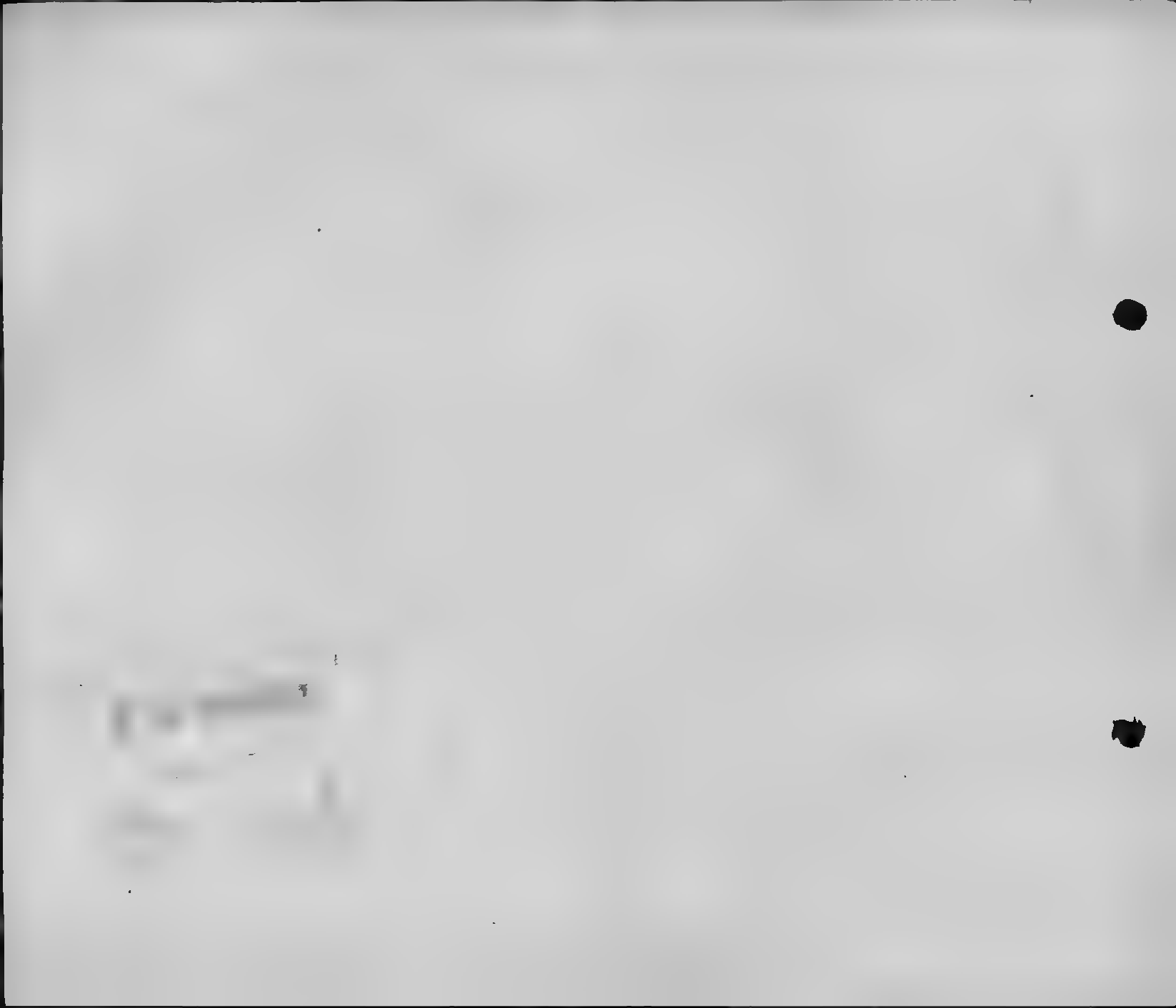
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 06285  
 Reg. Dist. No. 30

|   |                            |   |   |  |   |   |  |
|---|----------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH:  |                            |   |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |   |   |  |
| COUNTY <u>BALTIMORE</u>   |                            | MARYLAND  |   | STATE <u>MD</u>  |   | COUNTY <u>BALTIMORE</u>   |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  |                            | LENGTH OF STAY (in this place)  |   | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> <u>2-1-4</u> |   |   |  |
| TOWN <u>CADDOSVILLE</u>   |                            | <u>1 1/2 months</u>   |   | STREET ADDRESS <u>1715 PRATT St.</u> (If rural, give location)   |   |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE ST HOSP.</u>  |                            |   |   |  |   |   |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |                            |   |   | 4. DATE OF DEATH (Month) (Day) (Year)  |   |   |  |
| <u>LYDIA BAKER MORGAN</u>   |                            |   |   | <u>7 15 19 55</u>  |   |   |  |
| 5. SEX: <u>F</u>  | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>  | 8. DATE OF BIRTH: <u>10/16/1879</u>         | 9. AGE last birthday: <u>75</u> yrs.   | 10. IF UNDER 1 YEAR: Months Days Hours Min. | 11. IF UNDER 24 HRS. Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u>  |                            |   | 10b. KIND OF BUSINESS OR INDUSTRY: <u>-</u> | 11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME: <u>BENNETT BAKER</u>   |                            |   |   | 14. MOTHER'S MAIDEN NAME: <u>MARY GRIZZARD</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)  |                            | 16. SOCIAL SECURITY No.: <u>none</u>  |   | 17. INFORMANT & ADDRESS: <u>Hosp. Records</u>  |   |   |  |
| 18. MEDICAL CERTIFICATION   |                            |   |   |  |   |   |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  |                            |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| <u>902.7</u><br>Immediate cause (a) <u>...</u><br>DUE TO<br>Antecedent cause(s) (b) <u>...</u><br>Diseases or conditions, if any, giving rise to the above cause DUE TO<br>stating underlying cause last (c) <u>...</u>   |                            |   |   |  |   |   |  |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>...</u>  |                            |   |   |  |   |   |  |
| 19a. DATE OF OPERATION: <u>...</u>  |                            | 19b. MAJOR FINDING OF OPERATION: <u>...</u>   |   |  |   | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>                             |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                            | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Hospital</u>                            |   | 21c. (City or town) (County) (State) <u>BALTIMORE BALT. MD.</u>  |   |   |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 10 1955 M.</u>  |                            | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR? <u>Fall from head</u>   |   |   |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                            |   |   |  |   |   |  |
| SIGNATURE <u>Victor C. Harty</u>  |                            | M. D.   |   | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7-1-55</u>                       |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>  |                            | DATE THEREOF <u>7/7/55</u>  |   | NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>  |   | LOCATION (City, town, or county) (State) <u>Tarboro, N.C.</u>                                     |  |
| DATE REQD BY LOCAL REC <u>...</u>   |                            | REGISTRAR'S SIGNATURE <u>...</u>  |   | 24. FUNERAL DIRECTOR <u>...</u>  |   | ADDRESS <u>...</u>  |  |



Item 18 Film G184 8-2-55 am

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

|  |                   |  |                   |
|--|-------------------|--|-------------------|
| 1. PLACE OF DEATH  |                   | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                   |
| COUNTY <u>BALTIMORE</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <u>MT. WILSON</u> <u>97 days</u><br>HOSPITAL OR INSTITUTION OR<br>STREET ADDRESS <u>MT. WILSON STATE HOSPITAL</u>      |                   | STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u><br>CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <u>SEVERN</u> <u>02X-2</u><br>STREET ADDRESS (If rural give location)<br><u>EVERGREEN ROAD</u>   |                   |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |                   | 4. DATE (Month) (Day) (Year) OF DEATH:   |                   |
| <u>CHARLES TYDINGS NICHOLSON</u>   |                   | <u>7 - 3 - 1955</u>  |                   |
| 5. SEX:  | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  | 8. DATE OF BIRTH: |
| <u>MALE</u>  | <u>WHITE</u>      | <u>MARRIED</u>   | <u>4-23-1885</u>  |
| 9. AGE last birthday   |                   | IF UNDER 1 YEAR IF UNDER 24 HRS.   |                   |
| <u>70</u> yrs.   |                   | Months Days Hours Min.   |                   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):   |                   | 10B. KIND OF BUSINESS OR INDUSTRY:   |                   |
| <u>MAINTENANCE MAN DISTRICT TRAINING SCHOOL</u>  |                   | <u>MARYLAND</u>  |                   |
| 11. BIRTHPLACE (State or foreign country):   |                   | 12. CITIZEN OF WHAT COUNTRY?   |                   |
| <u>MARYLAND</u>  |                   | <u>U. S. A.</u>  |                   |
| 13. FATHER'S NAME:   |                   | 14. MOTHER'S MAIDEN NAME:  |                   |
| <u>NICHOLAS REVERDY NICHOLSON</u>  |                   | <u>ANNE MARIA TYDINGS.</u>   |                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |                   | 16. SOCIAL SECURITY NO.  |                   |
| <u>NO</u>  |                   | <u>269-14-2915</u>   |                   |
| 17. INFORMANT & ADDRESS  |                   | 18. MEDICAL CERTIFICATION  |                   |
| <u>ANNE NICHOLSON EVERGREEN ROAD SEVERN MD.</u>  |                   | I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><u>163X</u><br>IMMEDIATE CAUSE (A) <u>CARCINOMA OF THE LUNG</u><br>ANTECEDENT CAUSE (B) <u>PULMONARY TUBERCULOSIS</u><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>002x</u> |                   |
| 19. DATE OF OPERATION:   |                   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                   |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?   |                   | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                   |
| 21E. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |                   | 21F. HOW DID INJURY OCCUR?   |                   |
| 22. I hereby certify that I attended the deceased from <u>3-29-1955</u> , to <u>7-3-1955</u> ; that I last saw the deceased alive on <u>7-3-1955</u> , and that death occurred at <u>9 A. M.</u> from the causes and on the date stated above. |                   |  |                   |
| SIGNATURE <u>William H. King</u>   |                   | ADDRESS <u>MT. WILSON MARYLAND</u>   |                   |
| DATE SIGNED <u>7-3-55</u>  |                   | DATE SIGNED  |                   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                   | 24. NAME OF CEMETERY OR CREMATORY  |                   |
| <u>Burial</u>  |                   | <u>Epiphany Ch. Cem. Odenton Md.</u>   |                   |
| 25. DATE REC'D BY LOCAL REGISTRAR <u>July 5, 1955</u>  |                   | 26. REGISTRAR'S SIGNATURE <u>Dorothy Russell</u>   |                   |
| 27. FURNERAL DIRECTOR <u>L. J. DeAlba</u>  |                   | 28. ADDRESS <u>1111 King Street, Baltimore, Md.</u>  |                   |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8 2 0 0

10 2 71



06387

6388

## MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Items 18, 21, 22 Film 3186 9-13-55

Reg. Dist. No. 30

|   |                           |  |                                    |
|---|---------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>COUNTY Baltimore   |                           | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE Maryland COUNTY Prince George                                   |                                    |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN Catonsville                 |                           | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN Laurel                        |                                    |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br>Spring Grove State Hosp.                                     |                           | STREET ADDRESS (If rural, give location)<br>321 Montgomery St.   |                                    |
| 3. NAME OF DECEASED<br>(Type or Print)  |                           | 4. DATE OF DEATH   |                                    |
| (First) (Middle) (Last)<br>WILLIAM F. SROD NICOLL   |                           | (Month) (Day) (Year)<br>July 30 1955   |                                    |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married   | 8. DATE OF BIRTH<br>Sept. 27, 1882 |
| 9. AGE last birthday<br>72 yrs.   |                           | 10. BIRTHPLACE (State or foreign country)<br>Baltimore, Md.  |                                    |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>accountant |                           | 11b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Government   |                                    |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                           | 13. FATHER'S NAME<br>Samuel Pentz Nicoll   |                                    |
| 14. MOTHER'S MAIDEN NAME<br>Christine Carrie Oliver   |                           | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>no |                                    |
| 16. SOCIAL SECURITY No.   |                           | 17. INFORMANT AND ADDRESS<br>Mrs. Betty N. Hopkins, Laurel, Md.  |                                    |

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

1. Immediate cause (a) Extensive intra-pulmonary hemorrhage secondary to a fall

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Fracture of 12th thoracic vertebra

|   |  |  |
|---|--|--|
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH | PLACE (Home, farm, factory, street, office bldg., etc.)<br>Home  | (CITY OR TOWN) (COUNTY) (STATE)<br>Laurel Pr. George Md.                         |
| TIME (Month) (Day) (Year) (Hour)<br>OF INJURY July 24, 1955 m.                                    | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | HOW DID INJURY OCCUR?<br>Fell to kitchen floor                                   |

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural cause ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

REAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTERING SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Aug 1

Walter S. Perry

DeWitt Donaldson, Laurel, Md.

MARGIN RESERVED FOR BINDING

USE WHITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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6339

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                |  |                   |
|---|--------------------------------|--|-------------------|
| 1 PLACE OF DEATH:   |                                | 2 USUAL RESIDENCE (HOME) OF DECEASED:  |                   |
| COUNTY <b>BALTIMORE</b>   | MARYLAND                       | STATE <b>MARYLAND</b>  | COUNTY            |
| CITY (If outside corporate limits, write RURAL and give nearest town)   | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town)  |                   |
| <b>X</b> TOWN <b>FORT HOWARD</b>  | <b>1 DAY</b>                   | OR TOWN <b>BALTIMORE</b>   | <b>3V01-4</b>     |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                                | STREET ADDRESS (If rural give location)  |                   |
| <b>50 VETERANS ADMINISTRATION HOSPITAL</b>  |                                | <b>4912 PEMBRIDGE AVENUE</b>   |                   |
| 3. NAME OF DECEASED: (Type or Print)  |                                | 4. DATE (Month) (Day) (Year)   |                   |
| First (Middle) (Last)   |                                | OF DEATH   |                   |
| <b>JOHN (NMI) NOVEY</b>   |                                | <b>JULY 11 19 55</b>   |                   |
| 5. SEX:   | 6. COLOR OR RACE:              | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  | 8. DATE OF BIRTH: |
| <b>MALE</b>   | <b>WHITE</b>                   | <b>MARRIED</b>   | <b>7-4-99</b>     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired):   |                                | 10B. KIND OF BUSINESS OR INDUSTRY:   |                   |
| <b>POSTAL CLERK</b>   |                                |  |                   |
| 13. FATHER'S NAME:  |                                | 11. BIRTHPLACE (State or foreign country):   |                   |
| <b>ISAAC NOVEY</b>  |                                | <b>NEW YORK, N.Y.</b>  |                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service:  |                                | 14. MOTHER'S MAIDEN NAME:  |                   |
| <b>YES</b>  |                                | <b>HANNAH YARMARTZ</b>   |                   |
| 16. SOCIAL SECURITY NO.   |                                | 17. INFORMANT & ADDRESS:   |                   |
| <b>NONE</b>   |                                | <b>CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.</b>  |                   |
| 18. MEDICAL CERTIFICATION   |                                | INTERVAL BETWEEN ONSET AND DEATH   |                   |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                |  |                   |
| 420.0 IMMEDIATE CAUSE   |                                | UNKNOWN  |                   |
| ANTECEDENT CAUSE (S)  |                                |  |                   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |                                | UNKNOWN  |                   |
| (A) INFARCTION OF THE MYOCARDIUM  |                                |  |                   |
| (B) ARTERIOSCLEROTIC HEART DISEASE  |                                |  |                   |
| (C)   |                                |  |                   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                |  |                   |
| 19A. DATE OF OPERATION:   |                                | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                   |
| 19B. MAJOR FINDINGS OF OPERATION  |                                |  |                   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                        |                                | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)  |                   |
| 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)  |                                |  |                   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                   |
| 21F. HOW DID INJURY OCCUR?  |                                |  |                   |
| 22. I hereby certify that I attended the deceased from JULY 10, 1955, to JULY 11, 1955, and that death occurred at 11:30 PM from the causes and on the date stated above. |                                |  |                   |
| SIGNATURE   |                                | DATE SIGNED  |                   |
| <b>FRANCIS G. DICKEY, CHIEF MEDICAL SERVICE M.D. VAH FT. HOWARD, MD</b>   |                                | <b>7/12/55</b>   |                   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                                | NAME OF CEMETERY OR CREMATORY  |                   |
| <b>BURIAL</b>   |                                | <b>SHAAREI ZION CEMETERY</b>   |                   |
| DATE REC'D BY LOCAL REGISTRAR   |                                | LOCATION (City, town, or county) (State)   |                   |
| <b>7-13-55</b>  |                                | <b>BALTIMORE, MARYLAND</b>   |                   |
| REGISTRAR'S SIGNATURE   |                                | 24. FUNERAL DIRECTOR   |                   |
| <b>A.W. Hedrich</b>   |                                | <b>SOL LEVINSON BROTHERS INC. 1124-26 W. BALTO. MARYLAND</b>   |                   |
| ADDRESS   |                                | ADDRESS  |                   |
|   |                                | <b>NORTH AVE.</b>  |                   |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6390

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH:   |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                |  |  |  |
| COUNTY <b>BALTIMORE</b>  |  | MARYLAND                                       |  | STATE <b>MD.</b>  |  | COUNTY   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)                                    |  | LENGTH OF STAY (in this place)                 |  | CITY (If outside corporate limits, write RURAL and give nearest town) |  |  |  |
| OR TOWN <b>Owings Mills</b>  |  | <b>2 yrs 6 mos</b>                             |  | OR TOWN <b>BALTIMORE</b>  |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |  | <b>ROSEWOOD TR. SCHOOL</b>                     |  | STREET ADDRESS (If rural, give location)                              |  |  |  |
| 12   |  |  |  | <b>3934 FRISBY ST.</b>  |  |  |  |
| 3. NAME OF DECEASED: (Type or Print)   |  | (First) <b>MARY</b>                            |  | (Middle) <b>ALICE</b>   |  | (Last) <b>O'CONNOR</b>   |  |
| 5. SEX: <b>FEMALE</b>  |  | 6. COLOR OR RACE: <b>WHITE</b>                 |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>SINGLE</b>       |  | 4. DATE OF DEATH: (Month) <b>7</b> (Day) <b>16</b> (Year) <b>19 55</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>none</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY: <b>none</b> |  | 8. DATE OF BIRTH: <b>11-5-48</b>                                      |  | 9. AGE last birthday: <b>6</b> yrs.                                    |  |
| 11. BIRTHPLACE (State or foreign country): <b>BALTIMORE, MARYLAND</b>                                    |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>       |  |   |  |  |  |
| 13. FATHER'S NAME: <b>JAMES J. O'CONNOR</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME: <b>ALICE E. HOKEMEYER</b>                   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>no</b>                                |  | 16. SOCIAL SECURITY No.: <b>none</b>           |  | 17. INFORMANT & ADDRESS: <b>James J. O'Connor 3934 Frisby St</b>      |  |  |  |

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 18. MEDICAL CERTIFICATION   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH                                    |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  |  |   |  |   |  |   |  |
| 353.3 Immediate cause (a) <b>Serial Epilepsy &amp; Cerebral edema</b>   |  |   |  |   |  | 12 hrs  |  |
| Antecedent cause(s) (b) <b>DUE TO</b>   |  |   |  |   |  |   |  |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <b>DUE TO</b>  |  |   |  |   |  |   |  |
| II. OTHER SIGNIFICANT CONDITIONS: <b>Congenital interventricular septal</b>   |  |   |  |   |  | Congenital  |  |
| Conditions contributing to the death but not related to the disease or condition causing death. <b>cardiac defect</b>   |  |   |  |   |  | 20. AUTOPSY?  |  |
| 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:   |  |   |  |   |  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| 21. ACCIDENT (Specify)  |  | PLACE (Home, farm, factory, street, office bldg., etc.)           |  | (CITY OR TOWN)  |  | (COUNTY) (STATE)  |  |
| SUICIDE HOMICIDE  |  | INJURY  |  |   |  |   |  |
| TIME (Month) (Day) (Year) (Hour)  |  | INJURY OCCURRED While at Not while                                |  | HOW DID INJURY OCCUR?                                 |  |   |  |
| OF INJURY   |  | M. work <input type="checkbox"/> at work <input type="checkbox"/> |  |   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>June 1, 1955</b> , to <b>July 16, 1955</b> , that I last saw the deceased alive on <b>July 16, 1955</b> , and that death occurred at <b>6:50 A.M.</b> , from the causes and on the date stated above. |  |   |  |   |  |   |  |
| SIGNATURE <b>Lila B. Johns</b>  |  | (DEGREE OR TITLE) <b>M.D.</b>                                     |  | ADDRESS <b>Rosewood Owings Mills, Md.</b>             |  | DATE SIGNED <b>7-16-55</b>  |  |
| 23. BURIAL, CREMATION REMOVAL <b>Burial</b>   |  | DATE THEREOF <b>July 19, 1955</b>                                 |  | NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>    |  | LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b> |  |
| DATE REC'D BY LOCAL REG.  |  | REGISTRAR'S SIGNATURE <b>John A. Moran</b>                        |  | 24. FUNERAL DIRECTOR ADDRESS <b>3000 E. Baltimore</b> |  |   |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6391

## CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH:   |  |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |  |  |
| COUNTY <u>Baltimore</u>  |  | MARYLAND  |  | STATE <u>Maryland</u>  |  | COUNTY <u>Baltimore</u>                  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>   |  | LENGTH OF STAY (in this place) <u>5 years</u>   |  | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> |  | X  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1100 Boyce Ave</u>  |  |   |  | STREET ADDRESS (If rural give location)  |  | X  |  |
| 3. NAME OF DECEASED: (First) <u>Flora Belle</u> (Middle) <u>Chlor</u> (Last) <u>Chlor</u>  |  |   |  | 4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>21st</u> (Year) <u>1955</u>             |  |  |  |
| 5. SEX: <u>Female</u>  |  | 6. COLOR OR RACE: <u>White</u>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>                         |  | 8. DATE OF BIRTH: <u>March 20, 1886</u>  |  |
| 9. AGE last birthday: <u>69</u> yrs.   |  | 10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Business</u> |  | 11. BIRTHPLACE (State or foreign country): <u>Frederick, Md</u>                        |  | 12. CITIZEN OF WHAT COUNTRY?             |  |
| 13. FATHER'S NAME: <u>Samuel Chlor</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME: <u>Susan Ann</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)   |  | 16. SOCIAL SECURITY No.: <u>✓</u>   |  | 17. INFORMANT & ADDRESS: <u>Lillian L. LeCombe, Home</u>                               |  |  |  |
| 18. MEDICAL CERTIFICATION  |  |   |  |  |  |  |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |   |  |  |  |  |  |
| Immediate cause (a) <u>Cerebral thrombosis</u>   |  |   |  |  |  |  |  |
| Antecedent causes (s) (b) <u>Arteriosclerosis &amp; senility</u>   |  |   |  |  |  |  |  |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)  |  |   |  |  |  |  |  |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION:  |  |   |  | 19b. MAJOR FINDINGS OF OPERATION   |  |  |  |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |   |  |  |  |  |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  |  | PLACE (Home, farm, factory, street, office bldg., etc.)   |  | (CITY OR TOWN)   |  | (COUNTY) (STATE)                         |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>         |  | HOW DID INJURY OCCUR?  |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>1950</u> to <u>7-21</u> , 1955, that I last saw the deceased alive on <u>7-20</u> , 1955, and that death occurred at <u>11:00 AM</u> from the causes and on the date stated above. |  |   |  |  |  |  |  |
| SIGNATURE <u>A. L. Ewasko</u>  |  | (Degree or title)   |  | ADDRESS <u>36 York St</u>  |  | DATE SIGNED <u>7/22/55</u>               |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)   |  | DATE THEREOF <u>July 23/55</u>  |  | NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>   |  | LOCATION (City, town, or county) (State) |  |
| DATE REC'D BY LOCAL REGISTRAR <u>7-22-55</u>   |  | REGISTRAR'S SIGNATURE <u>A. L. Ewasko</u>   |  | 24. FUNERAL DIRECTOR <u>F. B. Murphy</u>   |  | ADDRESS <u>131 E. Enoch Ave</u>          |  |

MARGIN RESERVED FOR BINDING



6392

06391

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No.

Reg. Dist.

|   |  |   |                                    |
|---|--|---|------------------------------------|
| 1. PLACE OF DEATH:  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |                                    |
| COUNTY <u>Baltimore</u>   | MARYLAND   | STATE <u>Md.</u>  | COUNTY <u>Baltimore</u>            |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br>TOWN <u>Rockdale</u>                | LENGTH OF STAY (in this place)<br><u>15 months</u> | CITY (If outside corporate limits write RURAL and give nearest town)<br>OR TOWN <u>Rockdale</u> | X                                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3625 Rockdale Terrace</u>  |  | STREET ADDRESS (If rural, give location)<br><u>3625 Rockdale Terrace</u>                        |                                    |
| 3. NAME OF DECEASED:  |  | 4. DATE OF DEATH  |                                    |
| (First) <u>Elizabeth</u>  | (Middle) <u>Olsen</u>                              | (Month) <u>July</u>   | (Day) <u>5</u> (Year) <u>1955</u>  |
| 5. SEX: <u>Female</u>   | 6. COLOR OR RACE: <u>White</u>                     | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>                                | 8. DATE OF BIRTH: <u>abt. 1874</u> |
| 9. AGE last birthday: <u>Over 80</u> yrs.   |  | 10. IF UNDER 1 YEAR: Months Days Hours Min.   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>      |  | 10b. KIND OF BUSINESS OR INDUSTRY: <u>At Home</u>   |                                    |
| 11. BIRTHPLACE (State or foreign country): <u>England</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>England</u>   |                                    |
| 13. FATHER'S NAME: <u>John McAdell</u>  |  | 14. MOTHER'S MAIDEN NAME: <u>Emma Cooper</u>  |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) |  | 16. SOCIAL SECURITY No.: <u>None</u>  |                                    |
| 17. INFORMANT & ADDRESS: <u>H.L. Zouh - 3625 Rockdale Terrace</u>   |  |   |                                    |

|  |                            |                                  |
|--|----------------------------|----------------------------------|
| 18. MEDICAL CERTIFICATION  |                            | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |                            |                                  |
| Immediate cause (a) DUE TO   | <u>Pulmonary Edema</u>     | <u>12 hrs.</u>                   |
| Antecedent cause(s) (b) DUE TO   | <u>Chronic Myocarditis</u> | <u>1 yr.</u>                     |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | <u>Art. Sclerosis</u>      | <u>2-3 yrs.</u>                  |

|   |   |  |
|---|---|--|
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                       |   |  |
| <u>Fractures left leg</u>   |   | <u>3 mos.</u>  |
| 19a. DATE OF OPERATION: <u>April 22, 1955</u>   | 19b. MAJOR FINDING OF OPERATION: <u>Extensive cuts applied</u>  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>Accident</u> | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Home</u>                               | 21c. (City or town) (County) (State)<br><u>3625 Rockdale Terrace - Balt. Md.</u> |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>April 21, 1955 - 2 p.m.</u>   | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>Fell one step in kitchen</u>                       |

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE D. D. Tupper CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 7-5-55  
 M. D. DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

|  |   |  |  |
|--|---|--|--|
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Cremation</u> | DATE THEREOF: <u>July 6, 1955</u>         | NAME OF CEMETERY OR CREMATORY: <u>Landon Park Cemetery</u> | LOCATION (City, town, or county) (State): <u>Balt. Md.</u> |
| DATE REC'D BY LOCAL REG: <u>7-5-55</u>                     | REGISTRAR'S SIGNATURE: <u>[Signature]</u> | 24. FUNERAL DIRECTOR: <u>Lamorean</u>                      | ADDRESS: <u>4518 Liberty Heights Ave.</u>                  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

06392

2411 N. Charles Street, Baltimore

6393

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH:<br>COUNTY <u>BALTO.</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>MD</u> COUNTY <u>BALTO.</u>                           |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>TOWN SPARROWS POINT</u>  |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>TOWN SPARROWS POINT (19)</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>908 H. STREET</u>  |                                  | STREET ADDRESS (If rural, give location)<br><u>908 H ST.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or Print) <u>HARRY EDWARD OWENS</u>   |                                  | 4. DATE OF DEATH<br>(Month) <u>JULY</u> (Day) <u>7</u> (Year) <u>1955</u>                                |   |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>  | 8. DATE OF BIRTH<br><u>6 SEPT. 1895</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>ELECTRICIAN</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>WIRE MAN</u>   | 9. AGE last birthday<br><u>59</u> yrs. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Mins. <u>  </u> |
| 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>F. OWENS</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>(UNK)</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>213-07-3634</u>  |   |
| 17. INFORMANT AND ADDRESS<br><u>ESSIE J. OWENS - SAME ADDRESS</u>  |                                  | 18. MEDICAL CERTIFICATION  |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| Immediate cause (a) <u>Myocardial infarction</u>   |                                  | <u>6 mos.</u>  |   |
| Antecedent cause(s) (b) <u>Coronary atherosclerosis</u>  |                                  | <u>2 yrs</u>   |   |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>  </u>   |                                  | <u>  </u>  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |                                  | <u>  </u>  |   |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |                                  | <u>  </u>  |   |
| 21. ACCIDENT (Specify) <u>SUICIDE</u>  |                                  | PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>                                 |   |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>   |                                  | INJURY OCCURRED White at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>        |   |
| HOW DID INJURY OCCUR?  |                                  | <u>  </u>  |   |
| 22. I hereby certify that I attended the deceased from <u>June 1</u> , 19 <u>55</u> , to <u>July 7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 7</u> , 19 <u>55</u> , and that death occurred at <u>7:15 PM</u> m., from the causes and on the date stated above. |                                  |  |   |
| SIGNATURE <u>James H. Owens</u>  |                                  | ADDRESS <u>  </u> DATE SIGNED <u>  </u>  |   |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                                  | DATE <u>July 11, 1955</u>  |   |
| NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>   |                                  | LOCATION (City, town, or county) <u>Baltimore, MD</u> (State) <u>MD</u>                                  |   |
| DATE REC'D BY LOCAL REG. <u>July 11, 1955</u>  |                                  | GISTRAR'S SIGNATURE <u>Dr. Ramsey Starbuck</u>   |   |
| 24. FUNERAL DIRECTOR <u>  </u>   |                                  | ADDRESS <u>  </u>  |   |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUENOS AIRES

JUL 11 1967



06393

MARYLAND

STATE DEPARTMENT OF HEALTH

6394

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

|   |                               |   |  |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>COUNTY <b>Baltimore</b> MARYLAND   |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <b>Maryland</b> COUNTY <b>Balto.</b>               |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>   |                               | CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>         |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Offutt Memorial Nursing Home</b>   |                               | STREET ADDRESS (If rural, give location) <b>/</b>   |  |
| 3. NAME OF DECEASED<br>(Type or Print)  | (First) <b>MARY</b>           | (Middle) <b>BURK</b>  | (Last) <b>PACKARD</b>                  |
| 4. DATE OF DEATH  | (Month) <b>July</b>           | (Day) <b>30,</b>  | (Year) <b>1955</b>                     |
| 5. SEX <b>female</b>  | 6. COLOR OR RACE <b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>                                   | 8. DATE OF BIRTH <b>Sept. 19, 1875</b> |
| 9. AGE last birthday <b>79</b> yrs.   |                               | 10. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Md.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>   |  |
| 13. FATHER'S NAME <b>Henry Burk</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Louisa Homan Burk</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)   |                               | 16. SOCIAL SECURITY No. ....  |  |
| 17. INFORMANT AND ADDRESS <b>Champlain S. Packard, Jr., Monkton, Maryland</b>   |                               | 18. MEDICAL CERTIFICATION   |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                               | 2. INTERVAL BETWEEN ONSET AND DEATH   |  |
| (a) Immediate cause <b>Cerebral Vascular Accident</b>   |                               | <b>2 wks</b>  |  |
| (b) Antecedent cause(s) <b>Generalized + cerebral arteriosclerosis</b>  |                               | <b>1 year</b>   |  |
| (c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last  |                               |   |  |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |                               |   |  |
| 19a. DATE OF OPERATION  |                               | 19b. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>   |                               |   |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)   |                               | PLACE (Home, farm, factory, street, OF office bldg., etc.)  |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |                               | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  |
| HOW DID INJURY OCCUR?   |                               |   |  |
| 22. I hereby certify that I attended the deceased from <b>Sept. 19, 1955</b> to <b>July 30, 1955</b> , that I last saw the deceased alive on <b>July 29, 1955</b> , and that death occurred at <b>11:45</b> m., from the causes and on the date stated above. |                               |   |  |
| SIGNATURE <b>Wm. C. Packard, Jr.</b>  |                               | ADDRESS <b>Cockeysville Md.</b>   |  |
| DATE SIGNED <b>30 July 1955</b>   |                               |   |  |
| 23. BURIAL, CREMATION REMAINS (Specify) <b>Burial</b>   |                               | DATE <b>8/1/55</b>  |  |
| NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>  |                               | LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>                                |  |
| DATE REC'D BY LOCAL REG.  |                               | 24. FUNERAL DIRECTOR <b>Wm. C. Packard, Jr.</b>   |  |
| REGISTRAR'S SIGNATURE   |                               | ADDRESS <b>1217 St. Paul St.</b>  |  |

MARGIN RESERVED FOR BINDING



06394

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

6395

|  |                                  |  |  |   |   |
|--|----------------------------------|--|--|---|---|
| 1. PLACE OF DEATH-<br>CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Baltimore 4</u>   |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Baltimore 4</u>     |  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Maryland</u> COUNTY <u>Baltimore</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDR <u>1745 Yakona Rd.</u>  |                                  | LENGTH OF STAY (in this place)<br><u>7 yrs.</u>  |  | STREET ADDRESS (If rural, give location)<br><u>1745 Yakona Rd.</u>                      |   |
| 3. NAME OF DECEASED (Type or Print)<br>(First) <u>NAOMI</u> (Middle) <u>J.</u> (Last) <u>PARRIS</u>  |                                  | 4. DATE OF DEATH<br>(Month) <u>July</u> (Day) <u>12</u> (Year) <u>1953</u>                           |  |   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>                                      | 8. DATE OF BIRTH<br><u>Dec. 18, 1884</u> | 9. AGE last birthday<br><u>70</u> yrs.  | 10. If under 1 year<br>Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>At Home</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore</u>                           |   |
| 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>   |                                  | 13. FATHER'S NAME<br><u>Charles Calverton Egerton Hall</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Amanda Cornelia Gardner</u>                              |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>  |                                  | 16. SOCIAL SECURITY No.<br><u>no</u>   |  | 17. INFORMANT AND ADDRESS<br><u>Mr. James W. Parris, 1745 Yakona Rd. -4</u>             |   |
| 18. MEDICAL CERTIFICATION  |                                  |  |  |   |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                  |  |  |   |   |
| <p>4. Immediate cause (a) <u>Myocardial Degeneration</u></p> <p>Antecedent cause(s) (b) <u>Coronary Artery Disease</u></p> <p>(c)</p>  |                                  |  |  |   |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |                                  |  |  |   |   |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>                   |   |
| 21. ACCIDENT (Specify)<br>SUICIDE<br>HOMICIDE  |                                  | PLACE (Home, farm, factory, street, OF office bldg., etc.)<br>INJURY                                 |  | (CITY OR TOWN) (COUNTY) (STATE)   |   |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | INJURY OCCURRED<br>White at Work <input type="checkbox"/> Not White At work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>53</u> , to <u>July 18</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>July 18</u> , 19 <u>53</u> , and that death occurred at <u>5:50 P. M.</u> , from the causes and on the date stated above. |                                  |  |  |   |   |
| SIGNATURE: <u>Denis J. McGrath M.D.</u>  |                                  | (Degree or title)  |  | ADDRESS <u>8358 Loch Raven Blvd Balto. 4</u>  |   |
| DATE SIGNED <u>7/23/53</u>   |                                  | 23. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | DATE THEREOF <u>July 26, 1955</u>   |   |
| NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>   |                                  | LOCATION (City, town, or county) (State)<br><u>Pikesville, Balto. Co., Md.</u>                       |  | 24. FUNERAL DIRECTOR<br><u>John O. Mitchell &amp; Sons Inc.</u>                         |   |
| DATE REC'D BY LOCAL REG. <u>21-57</u>  |                                  | REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  | ADDRESS <u>1900 Eutaw Place, Balto.</u>   |   |

MARGIN RESERVED FOR INDEXING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



06205

MARYLAND

STATE DEPARTMENT OF HEALTH

6396

## CERTIFICATE OF DEATH

Reg. Dist. No. \_\_\_\_\_

|   |                                  |   |                                       |
|---|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH:<br>COUNTY <b>Baltimore</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <b>Maryland</b> COUNTY <b>Baltimore</b> |                                       |
| CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>   |                                  | CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>     |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1615 Naturo Road</b>   |                                  | STREET ADDRESS (If rural, give location) <b>1615 Naturo Road</b>                        |                                       |
| 3. NAME OF DECEASED<br>(Type or Print) <b>Mr. William E. Parrish</b>  |                                  | 4. DATE OF DEATH<br>(Month) <b>July</b> (Day) <b>13th</b> (Year) <b>1955</b>            |                                       |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>                         | 8. DATE OF BIRTH<br><b>10/16/1895</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Government Service</b> |                                  | 9. AGE last birthday <b>59</b> yrs. If under 1 year Months Days Hours Min.              |                                       |
| 11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>  |                                  | 12. CITIZEN OF WHAT Country <b>USA</b>  |                                       |
| 13. FATHER'S NAME<br><b>Mr. William Thomas Parrish</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Pauline Scott</b>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)                     |                                  | 16. SOCIAL SECURITY No.   |                                       |
| 17. INFORMANT AND ADDRESS<br><b>Mrs. Hattie L. Parrish. 1615 Naturo Road</b>  |                                  |   |                                       |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  | 18. MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 331X<br>Immediate cause   |  | (a) <i>Cerebral Hemorrhage</i>  |  | 1 week   |  |
| Antecedent cause(s)   |  | (b) <i>Arterial Hypertension</i>  |  | 5 years  |  |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last                                    |  | (c) ...   |  |  |  |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |   |  |  |  |
| 19a. DATE OF OPERATION <b>11</b>  |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)   |  | PLACE (Home, farm, factory, street, OF office bldg., etc.)  |  | (CITY OR TOWN) (COUNTY) (STATE)  |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?  |  |

22. I hereby certify that I attended the deceased from ..... 1940, to 7-13, 1955, that I last saw the deceased alive on 7-12, 1955, and that death occurred at 11 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

A.W. Hedrich  
dmr.

24. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, 5305 Harford Road #14

7-14-55

MARGIN RESERVED FOR BINDING

Dr. Peake



6397

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |   |
| COUNTY <b>Balto.</b>   | MARYLAND   | STATE <b>Md.</b>   | COUNTY  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   | LENGTH OF STAY (In this place)   | CITY (If outside corporate limits, write RURAL and give nearest town) OR         |   |
| TOWN <b>Catonsville</b>  |  | TOWN <b>Baltimore</b>  | <b>3431-4</b>   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |  | STREET ADDRESS (If rural give location)  |   |
| <b>House in the Pines</b>  |  | <b>5607 Wayne Ave.</b>   | <input checked="" type="checkbox"/>                           |
| 3. NAME OF DECEASED (Type or Print)  | (First) <b>FREDERICK</b>   | (Middle) <b>W.</b>   | (Last) <b>PAULUS</b>  |
| 4. DATE OF DEATH   | (Month) <b>7</b>   | (Day) <b>28</b>  | (Year) <b>1955</b>  |
| 5. SEX <b>male</b>   | 6. COLOR OR RACE <b>white</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <b>widowed</b>                  | 8. DATE OF BIRTH: <b>May 7, 1874</b>                          |
| 9. AGE last birthday: <b>81</b> yrs  | 10. MONTHS <b>7</b>  | 11. DAYS <b>28</b>   | 12. HOURS <b>19</b> MIN.                                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <b>Barber</b>  | 10B. KIND OF BUSINESS OR INDUSTRY: <b>Hotel</b>  | 11. BIRTHPLACE (State or foreign country): <b>Md.</b>                            | 12. CITIZEN OF WHAT COUNTRY?                                  |
| 13. FATHER'S NAME: <b>Charles Paulus</b>   | 14. MOTHER'S MAIDEN NAME: <b>Catherine Roth</b>  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>no</b>        | 16. SOCIAL SECURITY NO.                                       |
| 17. INFORMANT & ADDRESS: <b>Mrs. Samuel Lambdin - 5607 Wayne Ave.</b>  | 18. MEDICAL CERTIFICATION  |  |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  | INTERVAL BETWEEN ONSET AND DEATH                              |
| IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b>   |  |  | <b>1 da.</b>  |
| ANTECEDENT CAUSE (S) (B) <b>Hypertensive Cardio-Vascular Disease</b>   |  |  | <b>?</b>  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |  |  |   |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |   |
| 19A. DATE OF OPERATION:  | 19B. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)                                  | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)                     |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>7-25, 1955</b> , to <b>7-28, 1955</b> , that I last saw the deceased alive on <b>7-28, 1955</b> , and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above. |  |  |   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   | DATE THEREOF <b>7/30/55</b>  | NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>                               | LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b> |
| DATE REC'D BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE <b>[Signature]</b>   | 23. FUNERAL DIRECTOR <b>[Signature]</b>  | ADDRESS <b>Baltimore, Md.</b>                                 |

MARGIN RESERVE FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6398  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06397  
 Reg. Dist. No. 30

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH:  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |  |
| COUNTY <u>DALTA</u>   | MARYLAND  | STATE <u>MD.</u>  | COUNTY <u>DALTA</u>  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br>TOWN <u>CATONSVILLE</u>             | LENGTH OF STAY (in this place)  | CITY (If outside corporate limits write RURAL and give nearest town)<br>TOWN <u>CATONSVILLE</u> |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>1350 N. ROLLING RD.</u>   |   | STREET ADDRESS (If rural, give location)<br><u>1350 N. ROLLING RD.</u>                          |  |
| 3. NAME OF DECEASED:<br>(Type or Print)   | (First) <u>WORTHINGTON</u>  | (Last) <u>PEARCE</u>  | 4. DATE OF DEATH<br>(Month) <u>JULY</u> (Day) <u>26</u> (Year) <u>1955</u> |
| 5. SEX: <u>M</u>  | 6. COLOR OR RACE: <u>W</u>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWER</u>                                 | 8. DATE OF BIRTH: <u>1904</u>  |
| 9. AGE last birthday: <u>51</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>51</u> Days <u>51</u> Hours <u>51</u> Min. |   | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>MECHANIC</u>       | 10b. KIND OF BUSINESS OR INDUSTRY: <u>SELF EMP.</u>                     | 11. BIRTHPLACE (State or foreign country): <u>MD.</u>   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                    |
| 13. FATHER'S NAME:<br><u>JOHN M. PEARCE</u>   |   | 14. MOTHER'S MAIDEN NAME:<br><u>FLORENCE V.</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) |   | 16. SOCIAL SECURITY No.: <u>Raymond Swideman-1036 Cook Lane</u>                                 |  |
| 17. INFORMANT & ADDRESS:  |   |   |  |

|  |   |  |
|--|---|--|
| 18. MEDICAL CERTIFICATION  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |   |  |
| Immediate cause (a) <u>Asphyxiation, Carbon Monoxide gas</u>   |   |  |
| DUE TO   |   |  |
| Antecedent cause(s) (b) <u>Closed himself in auto using tank from</u>  |   |  |
| DISEASES OR CONDITIONS, IF ANY, giving rise to the above cause stating underlying cause last (c) <u>exhaust to inside of car</u>   |   |  |
| DUE TO   |   |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |   |  |
| 19a. DATE OF OPERATION:  | 19b. MAJOR FINDING OF OPERATION:  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>                                | 21c. (City or town) (County) (State)<br><u>Catonsville Balt. Md.</u>             |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 25 3:15 PM</u>   | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br><u>Carbon Monoxide from his auto</u>               |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |  |
| SIGNATURE <u>Dr. M. Kieffer</u> 1010 Leaden  |   |  |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>July 26 58</u>  |   |  |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |   |  |
| M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>   |   |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>   | DATE THEREOF <u>7-29-55</u>   | NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>                              |
| LOCATION (City, town, or county) (State)<br><u>Balt. Md.</u>   | 24. FUNERAL DIRECTOR <u>Trinity Funeral Home, Catonsville, Md.</u>  | ADDRESS  |
| DATE REC'D BY LOCAL REG. <u>7-29-55</u>  | REGISTRAR'S SIGNATURE <u>W. J. F. F. F.</u>   |  |



6399

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

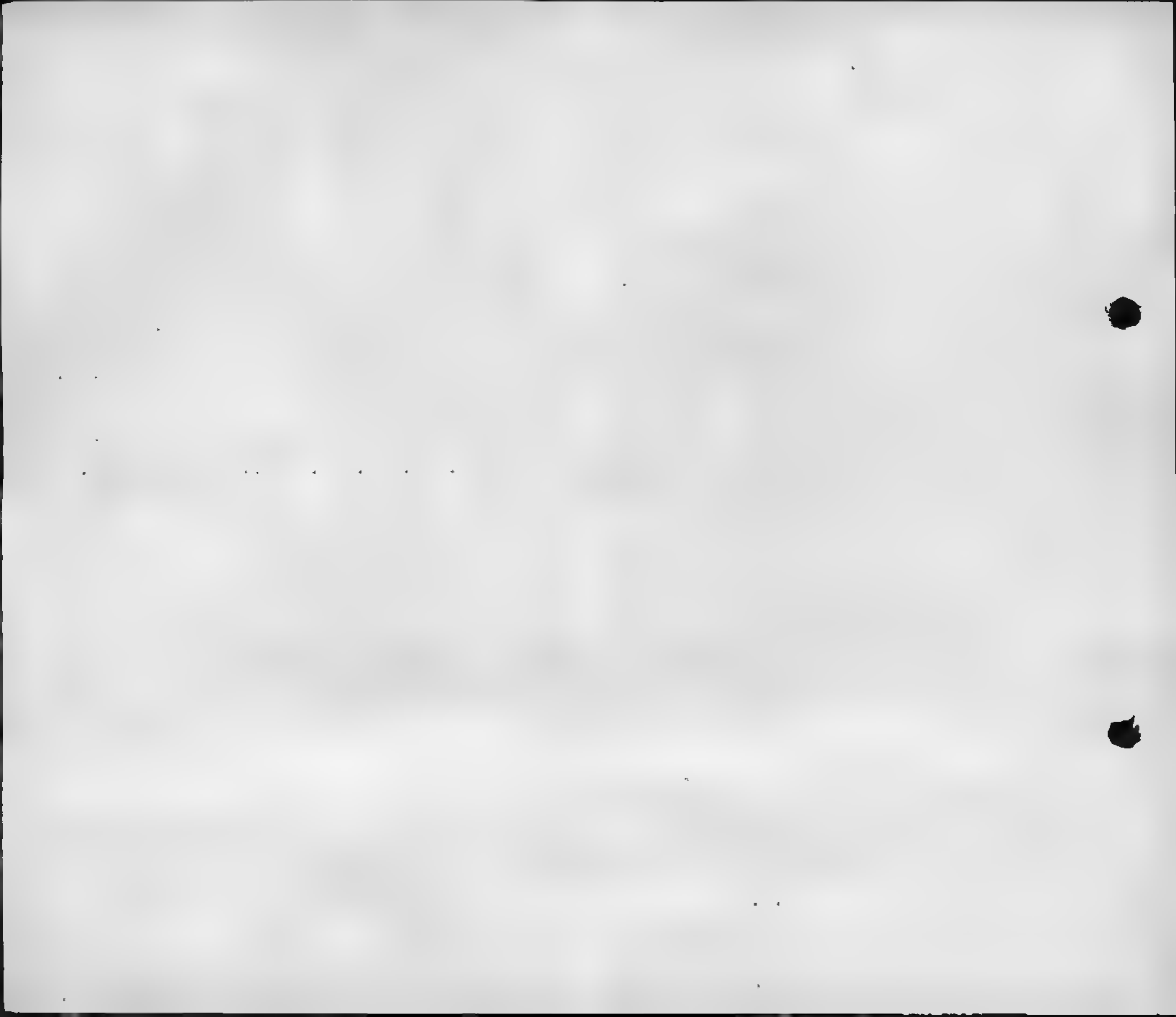
Reg. Dist. No.

6399

|  |  |  |                                 |
|--|--|--|---------------------------------|
| 1. PLACE OF DEATH  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                                 |
| COUNTY <b>BALTIMORE</b><br>CITY <b>Fort Howard</b><br>OR <b>TOWN</b><br>HOSPITAL OR INSTITUTE OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>  | MARYLAND<br>LENGTH OF STAY (in this place) <b>7 DAYS</b> | STATE <b>MARYLAND</b> COUNTY<br>CITY <b>BALTIMORE</b><br>OR <b>TOWN</b><br>STREET ADDRESS (If rural give location) <b>1822 E. CHASE STREET</b>           |                                 |
| 3. NAME OF DECEASED: (Type or Print) <b>CHRISTOPHER F. PERRY</b>   |  | 4. DATE (Month) (Day) (Year) OF DEATH: <b>JULY 9, 1955</b>   |                                 |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>COLORED</b>                          | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>SINGLE</b>   | 8. DATE OF BIRTH: <b>7/3/16</b> |
| 9. AGE last birthday <b>39</b> yrs   |  | 10. AGE last birthday (If under 1 year) (If under 24 hrs) Months Days Hours Min.   |                                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PACKER</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY: <b>CLOTHING MFG. CO.</b>  |                                 |
| 11. BIRTHPLACE (State or foreign country): <b>LANCASTER, VIRGINIA</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |                                 |
| 13. FATHER'S NAME: <b>CHRISTOPHER PERRY</b>  |  | 14. MOTHER'S MAIDEN NAME: <b>BLANCHE MN. WILTZ</b>   |                                 |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>YES</b> (If Yes, give war or dates of service) <b>WW II</b>  |  | 16. SOCIAL SECURITY No. <b>214-01-7731</b>   |                                 |
| 17. INFORMANT & ADDRESS: <b>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</b>  |  |  |                                 |
| 18. MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH   |                                 |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |  |                                 |
| (A) IMMEDIATE CAUSE <b>BRONCHOGENIC CARCINOMA, RIGHT LUNG</b>  |  | <b>8 MONTHS</b>  |                                 |
| (B) ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |  |  |                                 |
| (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>TUBERCULOSIS, PULMONARY, CHRONIC, MODERATELY ADVANCED, INACTIVE</b>   |  |  |                                 |
| 19A. DATE OF OPERATION <b>4-1-55</b>   |  | 19B. MAJOR FINDINGS OF OPERATION <b>Thoracotomy, right and excision of tissue for biopsy</b>   |                                 |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |                                 |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.   |                                 |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?   |  |  |                                 |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                 |
| 21F. HOW DID INJURY OCCUR?   |  |  |                                 |
| 22. I hereby certify that I attended the deceased from <b>JULY 2, 1955</b> , to <b>JULY 9, 1955</b> , and that death occurred at <b>6:10AM</b> , from the causes and on the date stated above. |  |  |                                 |
| SIGNATURE <b>CARIDAD GONZALEZ, M.D.</b>  |  | ADDRESS <b>M. D. VAH, FORT HOWARD, MARYLAND 7-9-55</b>   |                                 |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | DATE THEREOF <b>7-12-55</b>  |                                 |
| NAME OF CEMETERY OR CREMATORY <b>MOUNT CALVARY CEMETERY</b>  |  | LOCATION (City, town, or county) <b>BALTIMORE, MARYLAND</b>  |                                 |
| DATE REC'D BY LOCAL REGISTRAR <b>7-12-55</b>   |  | REGISTRAR'S SIGNATURE <b>A.W. Hedrich</b>  |                                 |
| 24. FUNERAL DIRECTOR <b>RANDOLPH COLLUCK FUNERAL HOME</b>  |  | ADDRESS <b>1412 E. PRESTON STREET, BALTIMORE, MD.</b>  |                                 |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07497

61 0

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

|   |   |  |   |  |   |
|---|---|--|---|--|---|
| 1. PLACE OF DEATH-<br>COUNTY <u>Baltimore</u>   |   | MARYLAND   |   | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Md.</u> COUNTY <u>Balto.</u>            |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>TOWN Essex</u>  |   | LENGTH OF STAY<br>(in this place)  |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>TOWN Essex</u> |   |
| HOSPITAL OR<br>INSTITUTION OR<br>STREET ADDRESS <u>Back River Neck Road-Box 850</u>   |   | STREET ADDRESS (If rural, give location)<br><u>Back River Neck Rd. - Box 850</u>   |   |  |   |
| 3. NAME OF<br>DECEASED<br>(Type or Print) <u>BURNETT A. PETTIT</u>  |   | (First) (Middle) (Last)  |   | 4. DATE<br>OF<br>DEATH <u>July 29th,</u> 19 <u>55</u>                                      |   |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>white</u>              | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED.<br>(Specify) <u>widowed</u>  | 8. DATE OF BIRTH<br><u>March 21, 1885</u> | 9. AGE last birthday<br><u>70 yrs.</u>   | If under 1 year<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work<br>done during most of working life, even if retired)<br><u>self-employed</u>  |   | 10b. KIND OF BUSINESS OR<br>INDUSTRY<br><u>restaurant owner</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Balto. Co., Md.</u>                        |   |
| 12. CITIZEN OF WHAT<br>COUNTRY? <u>USA</u>  |   | 13. FATHER'S NAME<br><u>Alexander Stevens Pettit</u>   |   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>no</u> (If yes, give war or dates of<br>service) |   |  |   |
| 16. SOCIAL SECURITY No.<br><u>220-07-2273</u>   |   | 17. INFORMANT AND ADDRESS<br><u>Mr. Henry Pettit, 911 Dulaney Valley St. (4)</u>   |   |  |   |
| 18. MEDICAL CERTIFICATION   |   |  |   |  |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |   |  |   |  | INTERVAL BETWEEN<br>ONSET AND DEATH       |
| Immediate cause (a) <u>Myocardial Infarction</u>  |   |  |   |  | <u>1 hr.</u>                              |
| Antecedent cause(s) (b) <u>Arteriosclerotic Heart Disease</u>   |   |  |   |  | <u>Years</u>                              |
| (c)   |   |  |   |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not<br>related to the disease or condition causing death.  |   |  |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. MAJOR FINDINGS OF OPERATION   |   |  |   |
| 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |  |   |  |   |
| 21. ACCIDENT<br>SUICIDE<br>HOMICIDE   | (Specify)                                     | PLACE (Home, farm, factory, street,<br>OF<br>office bldg., etc.)<br>INJURY   | (CITY OR TOWN)                            | (COUNTY)   | (STATE)                                   |
| TIME (Month) (Day) (Year) (Hour)<br>OF<br>INJURY  |   | INJURY OCCURRED<br>While at Not While<br>Work <input type="checkbox"/> At work <input type="checkbox"/>                  | HOW DID INJURY OCCUR?                     |  |   |
| 22. I hereby certify that I attended the deceased from <u>July 29, 1955</u> to <u>July 29, 1955</u> , that I last saw the deceased<br>alive on <u>July 29, 1955</u> , and that death occurred at <u>1:10 p.m.</u> , from the causes and on the date stated above. |   |  |   |  |   |
| SIGNATURE<br><u>Robert J. Lyden, M.D.</u>   |   | (Degree or title)  |   | ADDRESS<br><u>815 Eastern Ave Balt 47, Md.</u>   |   |
| DATE SIGNED<br><u>July 30, 1955</u>   |   |  |   |  |   |
| 23. BURIAL, CREMATION<br>REMOVAL (Specify)<br><u>burial</u>   | DATE THEREOF<br><u>8/2/55</u>                 | NAME OF CEMETERY OR CREMATORY<br><u>Oak Lawn Cemetery</u>  |   | LOCATION (City, town, or county)<br><u>Baltimore, Md.</u>                                  |   |
| DATE REC'D BY LOCAL<br>REG. <u>8/6/55</u>   | REGISTRAR'S SIGNATURE<br><u>Walter Murray</u> | 24. FUNERAL DIRECTOR<br><u>Lasswell Funeral Home</u>   |   | ADDRESS<br><u>7401 Belair Rd.</u>  |   |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100-100-100

815-100-100

Blue

100-100-100



MARYLAND

STATE DEPARTMENT OF HEALTH

6255

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

|   |                               |   |  |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH-<br>COUNTY <b>Baltimore</b> MARYLAND  |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <b>Maryland</b> COUNTY <b>Balto.</b>              |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>  |                               | CITY (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>              |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>829 Mildred Avenue</b>   |                               | STREET ADDRESS (If rural, give location) <b>829 Mildred Avenue</b>                                |  |
| 3. NAME OF DECEASED (Type or Print) <b>Mr. Daniel J. Phelan</b>   |                               | 4. DATE OF DEATH (Month) <b>July</b> (Day) <b>14th</b> (Year) <b>1955</b>                         |  |
| 5. SEX <b>male</b>  | 6. COLOR OR RACE <b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>widowed</b>                                   | 8. DATE OF BIRTH <b>March 29, 1870</b> |
| 9. AGE last birthday <b>85</b> yrs.   |                               | 10. If under 1 year: Months <b>14</b> Days <b>14</b> Hours <b>15</b> Min.                         |  |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired Hotel Clerk</b>  |                               | 11b. KIND OF BUSINESS OR INDUSTRY   |  |
| 12. FATHER'S NAME <b>Mr. Phelan</b>   |                               | 13. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>                              |  |
| 14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)   |                               | 15. SOCIAL SECURITY No.   |  |
| 16. MOTHER'S MAIDEN NAME <b>Anna Cornor</b>   |                               | 17. INFORMANT AND ADDRESS <b>Mrs. Warren Ridings, 829 Mildred Avenue</b>                          |  |
| 18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                               | 19. MEDICAL CERTIFICATION   |  |
| 444X Immediate cause  |                               | (a) <b>Heart failure</b>  |  |
| Antecedent cause(s)   |                               | (b) <b>Hypertension and age.</b>  |  |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last  |                               | (c)   |  |
| 20. OTHER SIGNIFICANT CONDITIONS  |                               | 21. INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>   |  |
| Conditions contributing to the death but not related to the disease or condition causing death.   |                               |   |  |
| 22a. DATE OF OPERATION  |                               | 22b. MAJOR FINDINGS OF OPERATION  |  |
| 23. ACCIDENT SUICIDE HOMICIDE (Specify)   |                               | 24. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY                             |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |                               | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  |
| HOW DID INJURY OCCUR?   |                               |   |  |
| 25. I hereby certify that I attended the deceased from <b>Oct 1950</b> to <b>14 July 55</b> , that I last saw the deceased alive on <b>8 July 1955</b> , and that death occurred at <b>08:50 A</b> m. from the causes and on the date stated above. |                               | 26. SIGNATURE <b>W. Morrison</b> (Degree or title) ADDRESS <b>3 Kinsleys Rd., Dundalk 22, Md.</b> |  |
| 27. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>   |                               | 28. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>                                     |  |
| DATE <b>July 18, 1955</b>   |                               | LOCATION (City, town, or county) <b>Baltimore, Md.</b>  |  |
| DATE REC'D BY LOCAL REG. <b>7-14-55</b>   |                               | 29. REGISTRAR'S SIGNATURE <b>A.W. Hedrich</b>   |  |
| 30. FUNERAL DIRECTOR <b>Leonard J. Ruck, 5305 Harford Road #14</b>  |                               | ADDRESS   |  |

MARGIN RESERVED FOR BINDING

I

Dr. Herbert Morrison  
3 Kinship

6266

## CERTIFICATE OF DEATH

Reg. Dist. No. 142

|  |                                   |  |  |
|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH:   |                                   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |
| COUNTY <b>Baltimore</b>  |                                   | STATE <b>Md</b> COUNTY <b>Baltimore</b>  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <b>Lansdowne</b>  |                                   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <b>Lansdowne</b>                    |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>224 Elizabeth Ave</b>  |                                   | STREET ADDRESS<br><b>224 Elizabeth Ave</b>   |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><b>Henry M. Poppam</b>   |                                   | 4. DATE OF DEATH: (Month) (Day) (Year)<br><b>July 4, 1955</b>  |  |
| 5. SEX:<br><b>male</b>   | 6. COLOR OR RACE:<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>widower</b>   | 8. DATE OF BIRTH:<br><b>Sept. 15, 1880</b> |
| 9. AGE last birthday: <b>74</b> yrs.   |                                   | 10. BIRTHPLACE (State or foreign country): <b>Md.</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Retired Mechanic</b>   |                                   | 11. BIRTHPLACE (State or foreign country): <b>Md.</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?   |                                   | 13. FATHER'S NAME:<br><b>unknown</b>   |  |
| 14. MOTHER'S MAIDEN NAME:<br><b>Nannie</b>   |                                   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)<br><b>none</b> |  |
| 16. SOCIAL SECURITY No.: <b>none</b>   |                                   | 17. INFORMANT & ADDRESS:<br><b>Bessie E. Barbee 224 Elizabeth Ave</b>  |  |
| 18. MEDICAL CERTIFICATION  |                                   |  |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |                                   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| Immediate cause (a) <b>Arteriosclerotic Cardiovascular Disease</b>   |                                   | <b>8 yrs.</b>  |  |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last   |                                   |  |  |
| 2. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.   |                                   |  |  |
| 19a. DATE OF OPERATION:  |                                   | 19b. MAJOR FINDINGS OF OPERATION:  |  |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |                                   |  |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  |                                   | PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)                              |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                   | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                    |  |
| HOW DID INJURY OCCUR?  |                                   |  |  |
| 22. I hereby certify that I attended the deceased from <b>Dec. 17, 1947</b> , to <b>July 4, 1955</b> , that I last saw the deceased alive on <b>June 12, 1955</b> , and that death occurred at <b>10:15 A.M.</b> , from the causes and on the date stated above. |                                   |  |  |
| SIGNATURE <b>C. Arthur Rosenberg M.D.</b>  |                                   | DEGREE OR TITLE ADDRESS <b>2436 Washington Blvd Balto-30</b>   |  |
| DATE SIGNED <b>7/5/55</b>  |                                   |  |  |
| 23. BURIAL, CREMATION REMOVAL (Specify): <b>Burial</b>   |                                   | DATE THEREOF <b>7-7-55</b>   |  |
| NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>   |                                   | LOCATION (City, town, or county) (State) <b>Baltimore</b>  |  |
| DATE REC'D BY LOCAL REG. <b>July 11 55</b>   |                                   | REGISTRAR'S SIGNATURE <b>Gertrude Kieffer</b>  |  |
| 24. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>  |                                   | ADDRESS <b>4107 Wilkens Ave</b>  |  |

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-136 Wash Blvd

11 10:10

3 A 100000

Low

10:10

6401

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH  |  |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                |  |  |  |
| COUNTY <u>Baltimore</u>  |  | MARYLAND  |  | STATE <u>MD</u>   |  | COUNTY <u>Balt</u>   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)  |  | LENGTH OF STAY (in this place)  |  | CITY (If outside corporate limits, write RURAL and give nearest town) |  | OR TOWN  |  |
| 55 <u>Towson</u>   |  |   |  | 57 <u>Towson</u>  |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5 1/2 Alley Lang Ave</u>  |  |   |  | STREET ADDRESS (If rural give location) <u>5 1/2 Alley Lang Ave</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or Print) <u>Claudius Lee Powell Sr.</u>   |  |   |  | 4. DATE (Month) (Day) (Year) OF DEATH: <u>July 16 - 1955</u>          |  |  |  |
| 5. SEX: <u>M</u>   |  | 6. COLOR OR RACE: <u>W</u>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>       |  | 8. DATE OF BIRTH: <u>Aug 4 - 1875</u>                          |  |
| 9. AGE last birthday <u>79</u> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Ironing &amp; Sew.</u> |  | 11. BIRTHPLACE (State or foreign country): <u>Powellville MD</u>      |  | 12. CITIZEN OF WHAT COUNTRY: <u>USA</u>                        |  |
| 13. FATHER'S NAME: <u>Elisba R. Powell</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME: <u>Laura L. Burbage</u>                     |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk) (If Yes, give war or dates of service): <u>No</u>   |  |   |  | 16. SOCIAL SECURITY NO.: <u>213-344258</u>                            |  | 17. INFORMANT & ADDRESS: <u>Amey K Powell 5 Alley Lang Ave</u> |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH                                      |  |  |  |
| IMMEDIATE CAUSE (A) <u>420.1 Coronary Thrombosis</u>   |  |   |  | 4 days  |  |  |  |
| ANTECEDENT CAUSE (S) (B) <u>Hypertensive Cardio-</u>   |  |   |  |   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Renal Vascular Disease</u>  |  |   |  | 15 yrs  |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION:  |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. PLACE (Home, farm, factory, etc) OF INJURY street, office bldg., etc   |  | 21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?          |  |  |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                |  | 21f. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>May 1955</u> , to <u>July 16, 1955</u> , that I last saw the deceased alive on <u>July 16, 1955</u> , and that death occurred at <u>8 1/2 M.</u> from the causes and on the date stated above. |  | 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | DATE THEREOF <u>July 19, 1955</u>                                     |  | NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>               |  |
| DATE REC'D BY LOCAL REGISTRAR <u>July 19, 1955</u>   |  | REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>  |  | 24. FUNERAL DIRECTOR <u>John Evans Sons</u>                           |  | ADDRESS <u>Towson</u>  |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. M. 100

5

64 2

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

|   |                 |  |                 |
|---|-----------------|--|-----------------|
| 1 PLACE OF DEATH:   |                 | 2 USUAL RESIDENCE (HOME) OF DECEASED:  |                 |
| COUNTY <b>BALTIMORE</b> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <b>FORT HOWARD</b> LENGTH OF STAY <b>8 DAYS</b><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b><br><b>3610 FRANKFORD AVENUE</b> |                 | STATE <b>MARYLAND</b> COUNTY<br>CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <b>BALTIMORE</b><br>STREET ADDRESS (If rural give location)<br><b>3610 FRANKFORD AVENUE</b>   |                 |
| 3 NAME OF DECEASED: (Type or Print)   |                 | 4 DATE (Month) (Day) (Year)  |                 |
| <b>JAMES W. PRALEY</b><br><b>MALE</b> <b>WHITE</b> <b>MARRIED</b><br><b>SALESMAN</b> <b>INSURANCE</b>   |                 | <b>DEATH JULY 8 1955</b><br><b>69</b> Months Days Hours Min.   |                 |
| 5 SEX   | 6 COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):   | 8 DATE OF BIRTH |
| <b>MALE</b>   | <b>WHITE</b>    | <b>MARRIED</b>   | <b>7-22-85</b>  |
| 10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):   |                 | 10B KIND OF BUSINESS OR INDUSTRY:  |                 |
| <b>SALESMAN</b>   |                 | <b>INSURANCE</b>   |                 |
| 13 FATHER'S NAME:   |                 | 14 MOTHER'S MAIDEN NAME.   |                 |
| <b>JOSEPH PRALEY</b>  |                 | <b>BARBARA (UNKNOWN)</b>   |                 |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |                 | 16 SOCIAL SECURITY NO.   |                 |
| <b>YES</b> <b>WW I</b>  |                 | <b>UNKNOWN</b>   |                 |
| 17. INFORMANT & ADDRESS.  |                 | 18. MEDICAL CERTIFICATION  |                 |
| <b>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</b>  |                 | I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><b>491X</b><br>IMMEDIATE CAUSE (A) <b>ASPIRATION PNEUMONIA</b><br>ANTECEDENT CAUSE (B) <b>8 DAYS</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.<br>(C) |                 |
| 19A. DATE OF OPERATION:   |                 | 19B. MAJOR FINDINGS OF OPERATION   |                 |
|   |                 |  |                 |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                 |  |                 |
| 21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                 | 21B PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)   |                 |
|   |                 | 21C WHERE DID (City or town) (County) (State) INJURY OCCUR?  |                 |
| 21D TIME (Month) (Day) (Year) (Hour) OF INJURY  |                 | 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                 |
|   |                 | 21F HOW DID INJURY OCCUR?  |                 |
| 22. I hereby certify that I attended the deceased from <b>JUNE 30, 1955, to JULY 8, 1955</b> , and that death occurred at <b>7:15A M.</b> from the causes and on the date stated above.   |                 |  |                 |
| SIGNATURE   |                 | DATE SIGNED  |                 |
| <b>WILLIAM B. VANDEGRIFT</b>  |                 | <b>7/8/1955</b>  |                 |
| 23 BURIAL, CREMATION, REMOVAL (SPECIFY)   |                 | NAME OF CEMETERY OR CREMATORY  |                 |
| <b>BURIAL</b>   |                 | <b>Holy Redeemer Cemetery</b>  |                 |
| DATE REC'D BY LOCAL REGISTRAR   |                 | LOCATION (City, town, or county) (State)   |                 |
| <b>July 9, 1955</b>   |                 | <b>4430 Belair Road, Balto. Md</b>   |                 |
| REGISTRAR'S SIGNATURE   |                 | 24. FUNERAL DIRECTOR   |                 |
| <b>R.W.</b>   |                 | <b>Leonard J. Ruck Funeral Home</b>  |                 |
|   |                 | <b>5305 Harford Balto. Md</b>  |                 |

MARGIN RESERVED FOR BINDING





6473

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

|  |                             |  |                                   |
|--|-----------------------------|--|-----------------------------------|
| 1 PLACE OF DEATH<br>COUNTY <u>Baltimore</u> MARYLAND<br>CITY (if outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u><br>TOWN <u>Stoneleigh</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>517 Overbrook Rd</u>               |                             | 2 USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Md</u> COUNTY <u>Baltimore</u><br>CITY (if outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u><br>OR TOWN <u>Stoneleigh</u><br>STREET ADDRESS (if rural give location) <u>517 Overbrook Rd</u> |                                   |
| 3. NAME OF DECEASED: (First) <u>MARTHA</u> (Middle) <u>M</u> (Last) <u>PRICE</u>   |                             | 4. DATE (Month) (Day) (Year) OF DEATH: <u>July 27 1955</u>   |                                   |
| 5. SEX: <u>F</u>   | 15. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>at home</u>   | 8. DATE OF BIRTH: <u>4-5-1910</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>  |                             | 10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>  |                                   |
| 13. FATHER'S NAME: <u>Thomas Daniel</u>  |                             | 14. MOTHER'S MAIDEN NAME: <u>Mary C. Price</u>   |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> If Yes, give war or dates of service: <u>—</u>   |                             | 16. SOCIAL SECURITY NO: <u>—</u>   |                                   |
| 17. INFORMANT'S ADDRESS: <u>Thomas P. Price - 517 Overbrook Rd</u>   |                             | 18. MEDICAL CERTIFICATION  |                                   |
| DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><u>321X</u><br>IMMEDIATE CAUSE<br>ANTECEDENT CAUSE (S):<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST  |                             | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Hour</u><br>(A) <u>Cerebral Hemorrhage</u><br>DUE TO<br>(B) <u>Choroidal Degeneration</u><br>DUE TO<br>(C)  |                                   |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                             |  |                                   |
| 19A. DATE OF OPERATION: <u>—</u>   |                             | 19B. MAJOR FINDINGS OF OPERATION: <u>—</u>   |                                   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                             |  |                                   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                             | 21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)  |                                   |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?   |                             |  |                                   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>July 27, 1955</u>  |                             | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work   |                                   |
| 21F. HOW DID INJURY OCCUR?   |                             |  |                                   |
| 22. I hereby certify that I attended the deceased from <u>July 27, 1955</u> , to <u>July 27, 1955</u> , that I last saw the deceased alive on <u>July 27, 1955</u> , and that death occurred at <u>2:00</u> M. from the causes and on the date stated above. |                             |  |                                   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>—</u>   |                             | DATE THEREOF: <u>July 30, 1955</u>   |                                   |
| NAME OF CEMETERY OR CREMATORY: <u>St. John's Cemetery</u>  |                             | LOCATION (City, town, or county) (State): <u>Baltimore Md</u>  |                                   |
| DATE REC'D BY LOCAL REGISTRAR: <u>—</u>  |                             | REGISTRAR'S SIGNATURE: <u>Charles F. Donnell</u>   |                                   |
| 24. FUNERAL DIRECTOR: <u>Wm. Cool Inc - 1217 St Paul</u>   |                             | ADDRESS: <u>—</u>  |                                   |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

64-3  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 54

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH:  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED.  |  |
| COUNTY <i>Balto.</i>  | MARYLAND                                    | STATE   | COUNTY                                 |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <i>Essex (middle Rte.)</i>  | LENGTH OF STAY (in this place)<br><i>12</i> | CITY (If outside corporate limits write RURAL and give nearest town)<br>TOWN <i>Same - Balto.</i> | <i>20</i>                              |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><i>1201 PL ST. E. R. ST.</i>   |   | STREET ADDRESS<br><i>(If rural, give location)</i>  | <i>54</i>                              |
| 3. NAME OF DECEASED:<br>(Type or Print)   |   | 4. DATE OF DEATH  |  |
| <i>(First) Sarah Elizabeth (Middle) Prince (Last)</i>   |   | <i>July 3 1955</i>  |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>white</i>            | 7. SINGLE, MARRIED, WIDOWED, DIVORCED.<br>(Specify)   | 8. DATE OF BIRTH<br><i>Sept 4/1889</i> |
| 9. AGE last birthday: <i>65</i> yrs   |   | 10. BIRTHPLACE (State or foreign country): <i>Solomons Id. U. S. A.</i>                           |  |
| 11. BIRTHPLACE (State or foreign country):  |   | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME:<br><i>Edward Evans</i>   |   | 14. MOTHER'S MAIDEN NAME:<br><i>Olivia Dougherty</i>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unk.)   |   | 16. SOCIAL SECURITY No:   |  |
| (If Yes, give war or dates of service)  |   | 17. INFORMANT & ADDRESS:<br><i>Milton King (Son-in-law)</i>                                       |  |
| 18. MEDICAL CERTIFICATION   |   |   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 585X Immediate cause (a)....  |   | <i>Coronary occlusion</i>   |  |
| Antecedent cause(s) (b).....  |   | <i>arthritis, &amp; Gall bladder infection</i>  |  |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)  |   | <i>Immediate 1 month</i>  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |   |   |  |
| 19a. DATE OF OPERATION:   |   | 19b. MAJOR FINDING OF OPERATION:  |  |
| 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |   |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY                            |  |
| 21c. (City or town) (County) (State)  |   | 21d. HOW DID INJURY OCCUR?  |  |
| 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |   |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |   |  |
| SIGNATURE <i>H. McArmstrong M.D.</i>  |   | DATE SIGNED   |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify):<br><i>Burial</i>  |   | DATE THEREOF<br><i>July 6, 1955</i>   |  |
| NAME OF CEMETERY OR CREMATORY<br><i>Wesley Chapel Cem.</i>  |   | LOCATION (City, town, or county) (State)<br><i>Rock Hall, Md.</i>                                 |  |
| DATE REC'D BY LOCAL REG.  |   | 24. FUNERAL DIRECTOR<br><i>Schimunek Funeral Home, Inc.</i>                                       |  |
| REGISTRAR'S SIGNATURE   |   | ADDRESS<br><i>2601-3-5 E. Madison St.</i>   |  |



6405

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH:   |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |   |
| COUNTY <u>BALTIMORE</u>  | MARYLAND  | STATE <u>MD</u>  | COUNTY <u>P. Geo. Co.</u>   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>57 TOWN CATONS VILLE</u>   | LENGTH OF STAY (In this place)<br><u>11 months</u>  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>LAUREL</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>14 SPRING GROVE ST. HOSP.</u>  |   | STREET ADDRESS (If rural give location)<br><u>MONTGOMERY RD.</u>                       |   |
| 3. NAME OF DECEASED (First) (Middle) (Last)<br><u>MARGARET PRITCHARD</u>   |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>7 4 1955</u>                               |   |
| 5. SEX: <u>F</u>   | 6. COLOR OR RACE: <u>W</u>  | 8. DATE OF BIRTH: <u>6/30/1883</u>   | 9. AGE last birthday (If under 1 year) (If under 24 hrs) Months Days Hours Min.<br><u>72 yrs.</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>chess maker</u>  | 10B. KIND OF BUSINESS OR INDUSTRY:<br><u>-</u>  | 11. BIRTHPLACE (State or foreign country):<br><u>VIRGINIA</u>                          | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |
| 13. FATHER'S NAME:<br><u>CHARLES PRITCHARD</u>   |   | 14. MOTHER'S MAIDEN NAME:<br><u>SARA PRITCHARD</u>                                     |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)<br><u>?</u>  |   | 17. INFORMANT & ADDRESS:<br><u>HOSPITAL RECORD</u>                                     |   |
| 18. MEDICAL CERTIFICATION  |   |  |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (A) <u>570.5</u><br><u>Gastrointestinal Obstruction</u>  |   |  | <u>7 days</u>   |
| ANTECEDENT CAUSE (B):<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST<br>(C)   |   |  |   |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH<br><u>Arterioscl. Cardio-Vasc. disease</u>  |   |  | <u>years</u>  |
| 19A. DATE OF OPERATION: <u>0</u>   |   | 19B. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   | 21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)                                     | 21C. WHERE DID (City or town) (County) (State)<br>INJURY OCCUR?                        |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><u>M.</u>   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <u>7/20</u> , 19 <u>54</u> , to <u>7/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/4</u> , 19 <u>55</u> , and that death occurred at <u>9.10 P.M.</u> from the causes and on the date stated above. |   |  |   |
| SIGNATURE <u>S. Wachler</u>  |   | ADDRESS <u>M.D. Spring Grove St. Hospital</u> DATE SIGNED <u>7/5/55</u>                |   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  | DATE THEREOF<br><u>7/7/55</u>   | NAME OF CEMETERY OR CREMATORY<br><u>Long Skell Cemetery Laurel, Maryland</u>           |   |
| DATE REC'D BY LOCAL REGISTRAR<br><u>7-6-55</u>   | REGISTRAR'S SIGNATURE<br><u>H.W. Seduc</u>  | 24. FUNERAL DIRECTOR<br><u>W.M. Cook, Inc., 1217 E. Paul St.</u>                       |   |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

|  |                           |   |   |  |  |
|--|---------------------------|---|---|--|--|
| 1. PLACE OF DEATH-<br>COUNTY <u>Baltimore</u> MARYLAND   |                           |   | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Md.</u> COUNTY <u>Har.</u>   |  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>                             |                           |   | CITY (If outside corporate limits, write RURAL and give nearest town) <u>51</u> |  |  |
| TOWN <u>Annapolis</u>  |                           |   | TOWN <u>Annapolis</u>   |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pop Line Nursing Home</u>   |                           |   | STREET ADDRESS (If rural, give location) <u>1000 June Rd</u>                    |  |  |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>W. J. J. Pugh</u>   |                           |   | 4. DATE OF DEATH (Month) (Day) (Year) <u>July 7, 1972</u>                       |  |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Feb. 8, 1972</u>  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vault Keeper</u>    |                           |   | 9. AGE last birthday <u>33</u> yrs. If under 1 year Months Days Hours Min.      |  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Indus.</u>  |                           |   | 11. BIRTHPLACE (State or foreign country) <u>Va.</u>                            |  |  |
| 13. FATHER'S NAME <u>Herman Raabe</u>  |                           |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) |                           |   | 14. MOTHER'S MAIDEN NAME <u>Not Known</u>                                       |  |  |
| 16. SOCIAL SECURITY No. <u>1-100-100000</u>  |                           |   | 17. INFORMANT AND ADDRESS <u>P. J. J. Pugh 1213 June Rd.</u>                    |  |  |

### 18. MEDICAL CERTIFICATION

|  |   |  |
|--|---|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| 332X Immediate cause (a) <u>Cerebral</u>   |   |  |
| Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>                |   |  |
| (c) <u>...</u>   |   |  |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>...</u> |   |  |
| 19a. DATE OF OPERATION   | 19b. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY                                 | (CITY OR TOWN) (COUNTY) (STATE)  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? <u>...</u>   |

22. I hereby certify that I attended the deceased from 12, 1972, to 7, 1972, that I last saw the deceased alive on 6, 1972, and that death occurred at 9:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

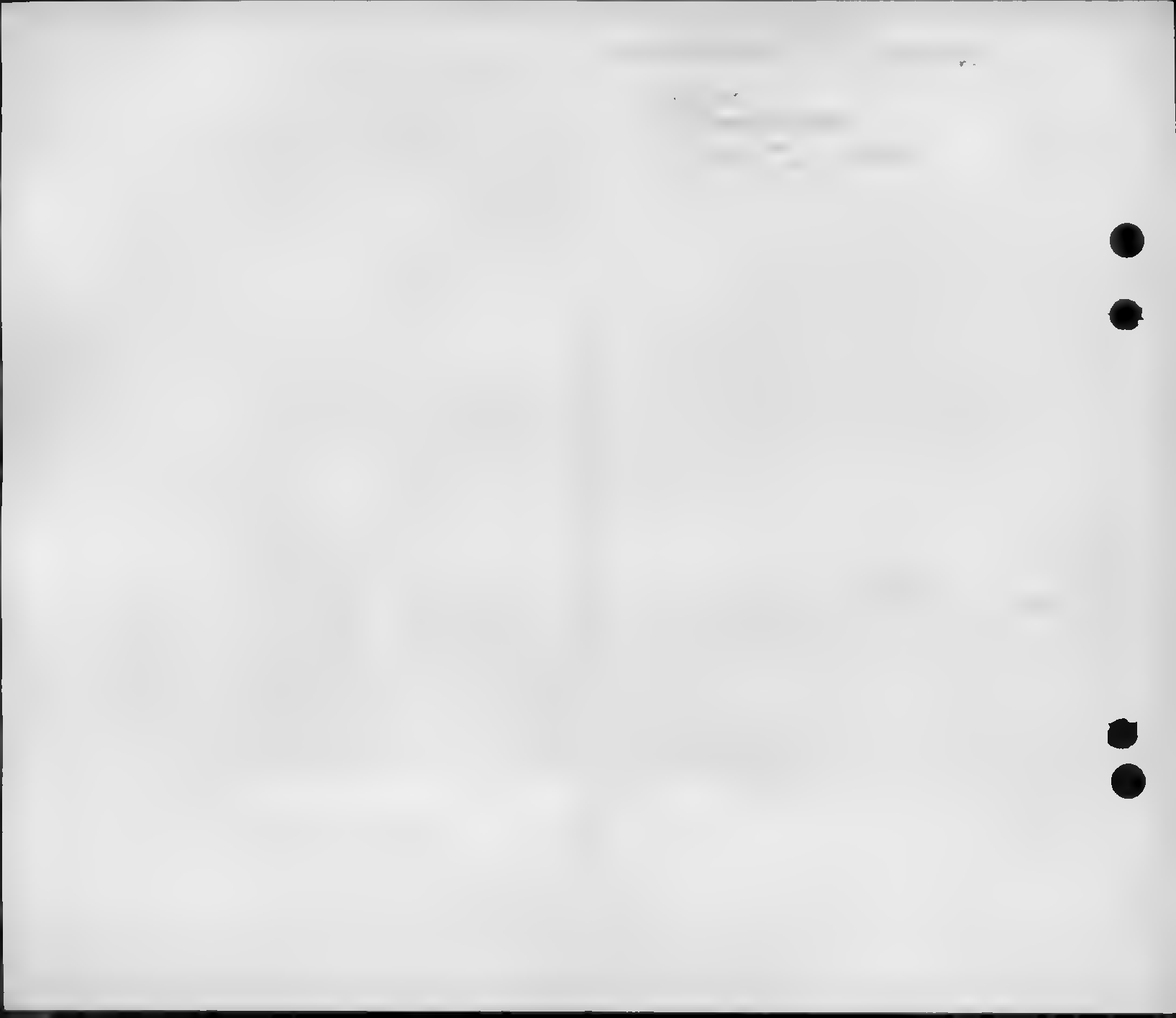
ADDRESS

DATE SIGNED

|  |                       |                               |  |
|--|-----------------------|-------------------------------|--|
| 23. BURIAL CREMATION REMOVAL (Specify) | DATE THEREOF          | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| <u>...</u>                             | <u>7-11-1955</u>      | <u>Oak Lawn</u>               | <u>Baltimore Co., Md.</u>                |
| DATE REC'D BY LOCAL REG.               | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR          | ADDRESS                                  |
| <u>...</u>                             | <u>...</u>            | <u>Fredrick A. Cole</u>       | <u>1013 W. Baltimore St.</u>             |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully! The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully! The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 06407 30

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>COUNTY <u>BALTO. COUNTY</u> MARYLAND <u>40</u>  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>M d.</u> COUNTY                                    |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>52 TOWN Catonsville</u>  |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>TOWN Brooklyn Park</u>   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>HOUSE IN THE PINES 16 FUETING AVE CATONSVILLE 28</u>   |                                  | STREET ADDRESS (If rural, give location)<br><u>7 Second Ave.</u>                                     |  |
| 3. NAME OF DECEASED (First) (Middle) (Last)<br><u>HARRY STILL RAY</u>  |                                  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>July 17 1955</u>   |  |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>                                      | 8. DATE OF BIRTH<br><u>9/23/77</u>     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>unknown</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Chemical Co.</u>   | 9. AGE last birthday<br><u>77</u> yrs. |
| 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>Parl Md.</u>  |  |
| 13. FATHER'S NAME<br><u>John W. Ray</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Clark</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>215-07-7682</u>  |  |
| 17. INFORMANT AND ADDRESS<br><u>Mr. Wilbur J. Ray-501 Church St., Brooklyn</u>   |                                  | 18. MEDICAL CERTIFICATION  |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><u>443X Immediate cause</u><br><u>(a) Myocardial Insufficiency</u><br><u>Antecedent cause(s)</u><br><u>(b) Chronic Myocarditis</u><br><u>(c) Chs. Hypertensive Cordis - Vasculis Disinosa</u>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 wks.</u><br><u>2 wks.</u><br><u>?</u>                       |  |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>Chs. Rheumatoid Arthritis</u>  |                                  | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                  |  |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION   |  |
| 21. ACCIDENT (Specify)<br>SUICIDE<br>HOMICIDE  |                                  | PLACE (Home, farm, factory, street, OF office bldg., etc.)<br>INJURY                                 |  |
| TIME (Month) (Day) (Year) (Hour)<br>OF INJURY  |                                  | INJURY OCCURRED<br>While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  |
| HOW DID INJURY OCCUR?  |                                  |  |  |
| 22. I hereby certify that I attended the deceased from <u>4-6</u> , 19 <u>48</u> , to <u>7-17</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>7-17</u> , 19 <u>50</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.<br>SIGNATURE <u>Wilbur J. Ray</u> (Degree or title) ADDRESS <u>Catonsville-28, Md.</u> DATE SIGNED <u>7-18-55</u> |                                  |  |  |
| 23. BURIAL, CREMATION, REBURYAL (Specify)<br><u>Burial</u>   |                                  | DATE THEREOF<br><u>7/20/55</u>   |  |
| NAME OF CEMETERY OR CREMATORY<br><u>Loudon Park Cem.</u>   |                                  | LOCATION (City, town, or county) (State)<br><u>Balto., Md.</u>                                       |  |
| DATE REG'D BY LOCAL REG.<br><u>7/17/55</u>   |                                  | 24. FUNERAL DIRECTOR<br><u>Robert E. Spencer</u> ADDRESS <u>1744 E. Baltimore St. Baltimore, Md.</u> |  |



MARYLAND

STATE DEPARTMENT OF HEALTH

6408

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

|  |                                  |   |                                     |
|--|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH-<br>COUNTY <u>Baltimore</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Maryland</u> COUNTY <u>Baltimore</u> |                                     |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Lutherville</u>                            |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |                                     |
| TOWN <u>Lutherville</u> LENGTH OF STAY (in this place)<br><u>13 months</u>   |                                  | TOWN <u>Towson</u>  |                                     |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor Nursing Home</u>  |                                  | STREET ADDRESS (If rural, give location)<br><u>7900 Knollwood Rd.</u>                   |                                     |
| 3. NAME OF DECEASED (Type or Print)<br>(First) <u>Clara</u> (Middle) <u>Corine</u> (Last) <u>Read</u>                  |                                  | 4. DATE OF DEATH (Month) <u>7</u> (Day) <u>11</u> (Year) <u>1955</u>                    |                                     |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>                          | 8. DATE OF BIRTH<br><u>5-9-1868</u> |
| 9. AGE last birthday<br><u>87</u> yrs.   |                                  | 10. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><u>Pennsylvania</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |                                     |
| 13. FATHER'S NAME<br><u>Otto M. Schaum</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Amelia E. Wehn</u>                                       |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)<br><u>No</u> |                                  | 16. SOCIAL SECURITY NO.<br><u>no</u>  |                                     |
| 17. INFORMANT AND ADDRESS<br><u>D. Roland Read 7900 Knollwood Rd. Towson Md</u>  |                                  |   |                                     |

18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

502.1

(a) Immediate cause

pneumonia

3 days

(b) Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

chronic bronchitissenility, generalized arteriosclerosis

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

|  |   |                       |          |         |
|--|---|-----------------------|----------|---------|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)    | PLACE (Home, farm, factory, street, office bldg., etc.)   | (CITY OR TOWN)        | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |          |         |

22. I hereby certify that I attended the deceased from July 11, 1955, to July 11, 1955, that I last saw the deceased alive on July 11, 1955, and that death occurred at 5:25 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

|   |                          |                               |                                  |           |
|---|--------------------------|-------------------------------|----------------------------------|-----------|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE                     | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State)   |
| <u>Cremation</u>                        | <u>July 14, 1955</u>     | <u>Greenmount</u>             | <u>Baltimore</u>                 | <u>Md</u> |
| DATE REC'D BY LOCAL REG.                | REGISTRAR'S SIGNATURE    | 24. FUNERAL DIRECTOR          | ADDRESS                          |           |
| <u>July 13, 1955</u>                    | <u>Clara H. Harkness</u> | <u>Glenn F. Lutz</u>          | <u>5209 York Rd</u>              |           |



6499

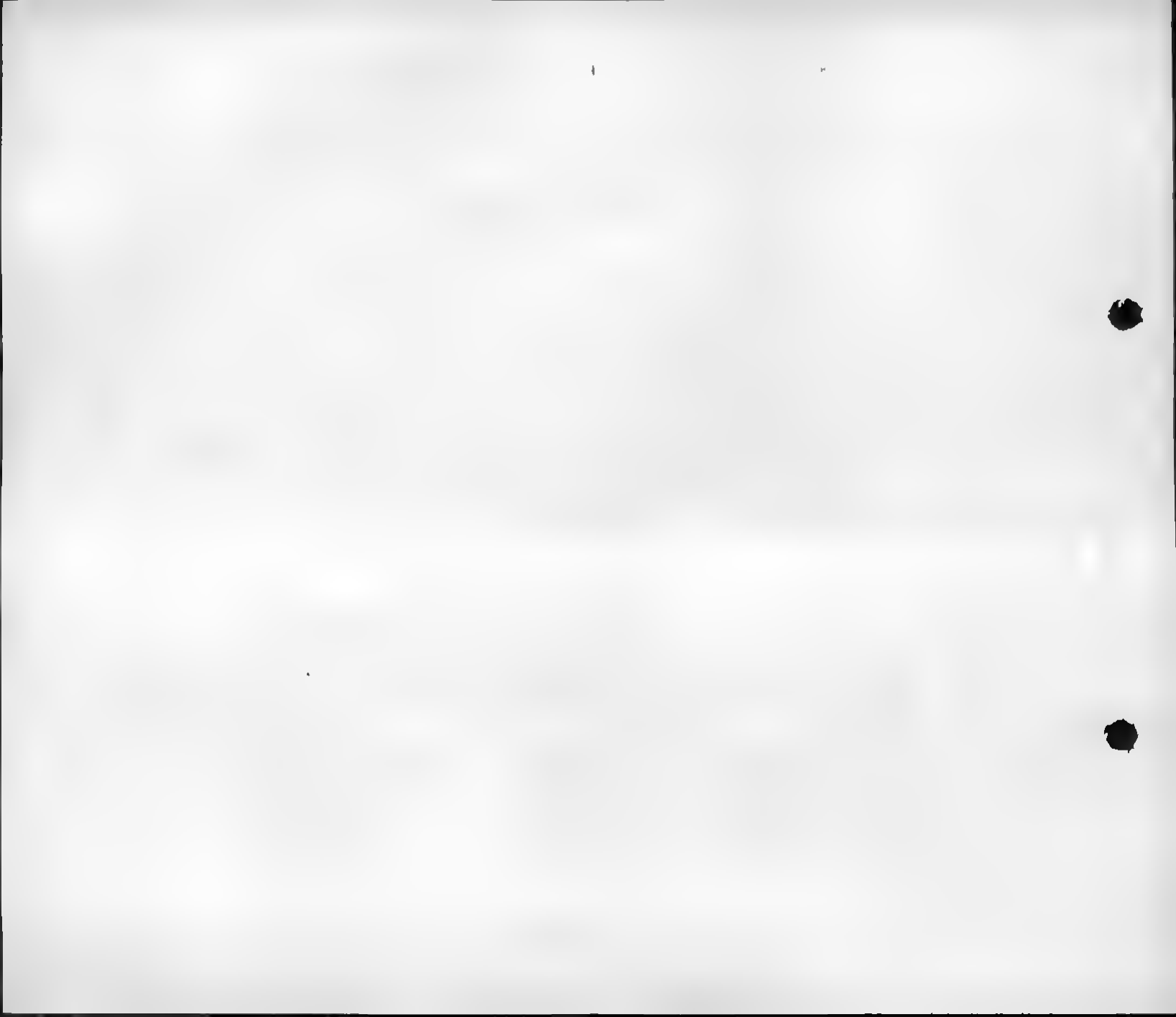
## CERTIFICATE OF DEATH

Reg. Dist. No. 30

|  |                            |  |   |  |  |   |  |
|--|----------------------------|--|---|--|--|---|--|
| 1. PLACE OF DEATH:<br><b>Spring Grove State Hospital</b><br>COUNTY <b>MARYLAND</b><br>CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>OR TOWN <b>27 days</b><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spring Grove State Hospital</b> |                            |  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <b>Maryland</b> COUNTY <b>Balto.</b><br>CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>OR TOWN <b>8 N. Rolling Rd.</b><br>STREET ADDRESS (If rural give location) |  |   |  |
| 3. NAME OF DECEASED:<br>(Type or Print) <b>John Martin Rebman</b>  |                            |  |   | 4. DATE (Month) (Day) (Year)<br>OF DEATH: <b>7 26 1955</b>   |  |   |  |
| 5. SEX: <b>M</b>   | 6. COLOR OR RACE: <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <b>married</b>  | 8. DATE OF BIRTH: <b>april 30, 1872</b> | 9. AGE last birthday: <b>83</b> yrs  |  | IF UNDER 1 YEAR: Months Days Hours Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Baker</b>  |                            |  |   | 10B. KIND OF BUSINESS OR INDUSTRY: <b>RETIRED</b>  |  | 11. BIRTHPLACE (State or foreign country): <b>Germany</b>                       |  |
| 13. FATHER'S NAME: <b>JOHN REBMANN</b>   |                            |  |   | 14. MOTHER'S MAIDEN NAME: <b>UNKNOWN</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk): <b>NO</b> (If Yes, give war or dates of service)   |                            |  |   | 16. SOCIAL SECURITY NO.: <b>217 14 1971</b>  |  | 17. INFORMANT ADDRESS: <b>Mrs. Marie Reib 1515 Tunlow Rd. Baltimore 18, Md.</b> |  |
| 18. MEDICAL CERTIFICATION  |                            |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                            |  |   |  |  |   |  |
| IMMEDIATE CAUSE: <b>334X</b>   |                            |  |   |  |  |   |  |
| ANTECEDENT CAUSE (S):  |                            |  |   |  |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |                            |  |   |  |  |   |  |
| (A) <b>Pneumonia</b>   |                            |  |   |  |  |   |  |
| DUE TO <b>Chronic brain syndrome associated with cerebral arteriosclerosis</b>   |                            |  |   |  |  |   |  |
| (B) <b>Parkinson's syndrome</b>  |                            |  |   |  |  |   |  |
| DUE TO   |                            |  |   |  |  |   |  |
| (C)  |                            |  |   |  |  |   |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                            |  |   |  |  |   |  |
| 19A. DATE OF OPERATION:  |                            |  |   | 19B. MAJOR FINDINGS OF OPERATION   |  |   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                            |  |   |  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                            | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |   | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?   |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>M</b>   |                            | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>6-30, 1955</b> , to <b>7-26, 1955</b> , that I last saw the deceased alive on <b>7-26, 1955</b> , and that death occurred at <b>8:00 PM</b> , from the causes and on the date stated above.                                    |                            |  |   |  |  |   |  |
| SIGNATURE <b>L. S. Williams</b>  |                            |  |   | ADDRESS <b>M.D. Spring Grove State Hosp.</b>   |  | DATE SIGNED <b>7-26-55</b>  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |                            | DATE THEREOF <b>JULY 30, 1955</b>  |   | NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>  |  | LOCATION (C.B., town, or county) (State) <b>BALTIMORE MARYLAND.</b>             |  |
| DATE REC'D BY LOCAL REGISTRAR <b>7/28/55</b>   |                            | REGISTRAR'S SIGNATURE <b>A.W. Hedrich</b>  |   | 24. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS INC.</b>   |  | ADDRESS <b>BALTIMORE MARYLAND.</b>  |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1806410

6267

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>COUNTY <u>Baltimore</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u><br>OR TOWN <u>10 Wps</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3169 Diaduct Ave</u>  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>Del.</u> COUNTY <u>Kent</u><br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>Clayton</u><br>OR TOWN <u>4' X</u><br>STREET ADDRESS (If rural give location) <u>Main St.</u>   |  |
| 3. NAME OF DECEASED:<br>(Type or Print) <u>Lula</u> (First) <u>Caray</u> (Middle) <u>Rees</u> (Last)<br>5. SEX: <u>Female</u> 6. COLOR OR RACE: <u>white</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u> 8. DATE OF BIRTH <u>June 20, 1882</u> 9. AGE last birthday <u>73</u> yrs. <u>0</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.                  |  | 4. DATE (Month) (Day) (Year) OF DEATH: <u>July 27</u> 19 <u>53</u>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10B. KIND OF BUSINESS OR INDUSTRY: <u>domestic</u> 11. BIRTHPLACE (State or foreign country): <u>Delaware</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  | 13. FATHER'S NAME: <u>Philip Caray</u> 14. MOTHER'S MAIDEN NAME: <u>Ruth Boggs</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT & ADDRESS: <u>Mrs Helen Brown 3169 Diaduct Relay 27, Md.</u>   |  | 18. MEDICAL CERTIFICATION<br>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><u>175X</u> IMMEDIATE CAUSE (A) <u>Cancer of ovary</u><br>ANTECEDENT CAUSE (S) DUE TO <u>General Arteriosclerosis 1942</u><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>General Arteriosclerosis 1942</u><br>(C) <u>Sensitivity</u> |  |
| 19A. DATE OF OPERATION: <u>1 May 1944</u> 19B. MAJOR FINDINGS OF OPERATION: <u>Cancer of ovary</u>   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?   |  | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u> 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <u>May 14 1953</u> , to <u>July 27 1953</u> , that I last saw the deceased alive on <u>July 27, 1953</u> , and that death occurred at <u>11<sup>15</sup> a</u> M, from the causes and on the date stated above.<br>SIGNATURE <u>D. B. Brumbaugh</u> ADDRESS <u>M.D. 3609 Main St Elphinstown</u> DATE SIGNED <u>7/27/53</u> |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>7/30/53</u> NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u> LOCATION (City, town, or county) (State) <u>Smymna Delaware</u>   |  | DATE REC'D BY LOCAL REGISTRAR <u>July 27, 53</u> REGISTRAR'S SIGNATURE <u>G. W. Kieffer</u> 24. FUNERAL DIRECTOR <u>G. W. Kieffer</u> ADDRESS <u>Smymna, Delaware</u>  |  |

THE UNIVERSITY

OF CALIFORNIA

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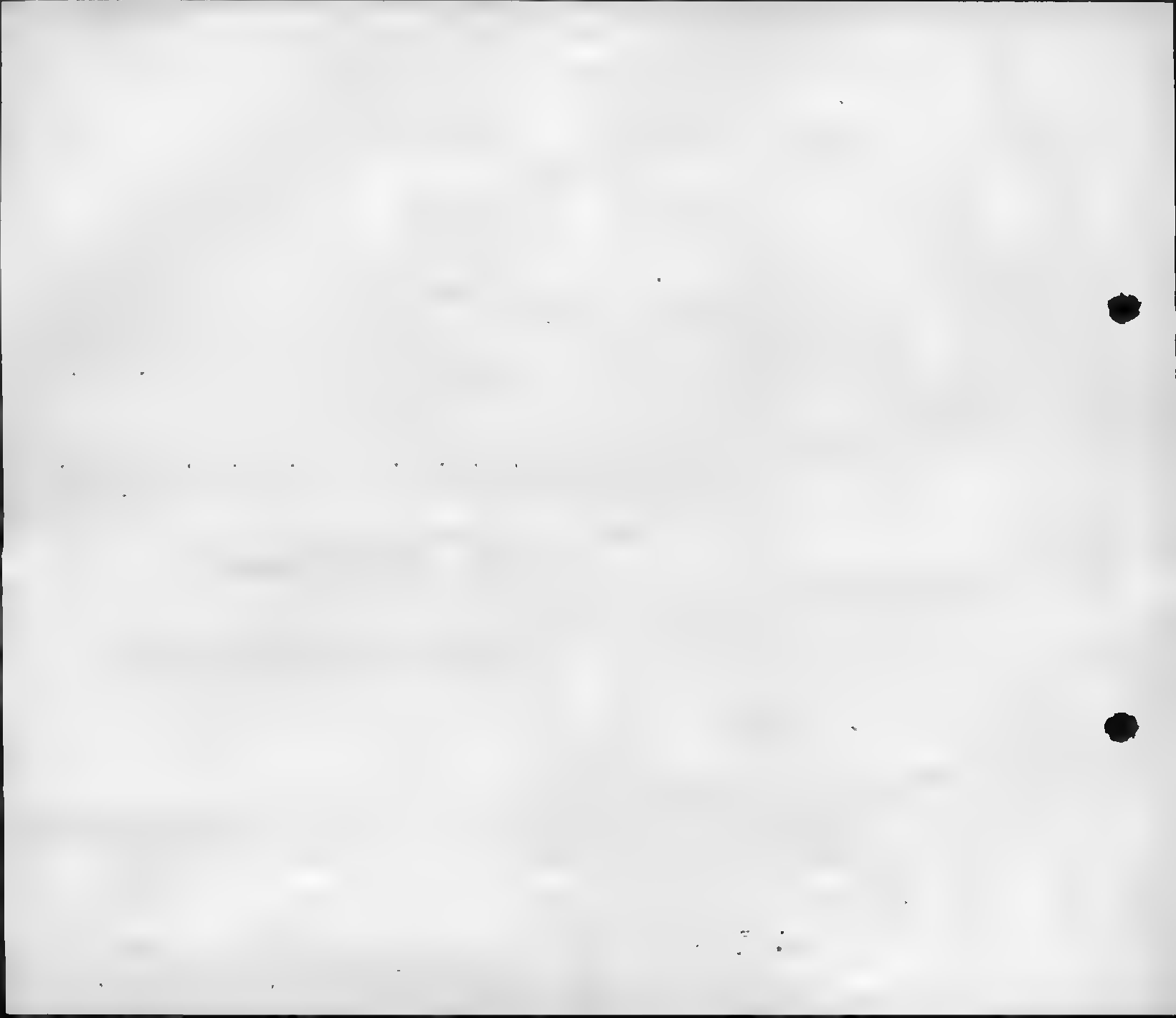


PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 <sup>06411</sup>  
6410  
CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |  |                                  |
|---|---|--|----------------------------------|
| 1. PLACE OF DEATH:  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                                  |
| COUNTY <b>BALTIMORE</b>   | MARYLAND  | STATE <b>MARYLAND</b>  | COUNTY                           |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <b>FORT HOWARD</b>  | LENGTH OF STAY (in this place)<br><b>4 DAYS</b> | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <b>BALTIMORE</b> | <b>3001-4</b>                    |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |   | STREET ADDRESS (If rural give location)<br><b>317 NORTH BEND ROAD</b>                                |                                  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><b>EDWARD L. REYNOLDS</b>   |   | 4. DATE (Month) (Day) (Year)<br>OF DEATH: <b>JULY 19 1955</b>  |                                  |
| 5. SEX: <b>MALE</b>   | 6. COLOR OR RACE: <b>WHITE</b>                  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>                                      | 8. DATE OF BIRTH: <b>6-19-96</b> |
| 9. AGE last birthday: <b>59</b> yrs   |   | 10. AGE UNDER 1 YEAR: Months Days  | 11. AGE UNDER 24 MRS. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>PURCHASING AGENT</b>                                    |   | 10B. KIND OF BUSINESS OR INDUSTRY:   |                                  |
| 11. BIRTHPLACE (State or foreign country): <b>TURBOTVILLE, PENNSYLVANIA</b>   |   | 12. CITIZEN OF WHAT COUNTRY: <b>U. S. A.</b>   |                                  |
| 13. FATHER'S NAME: <b>HARRY REYNOLDS</b>  |   | 14. MOTHER'S MAIDEN NAME: <b>MARGARETTA WETZEL</b>   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If Yes, give date of service) <b>YES</b>   |   | 16. SOCIAL SECURITY NO.: <b>Unknown</b>  |                                  |
| 17. INFORMANT & ADDRESS: <b>CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.</b>  |   |  |                                  |
| 18. MEDICAL CERTIFICATION   |   | INTERVAL BETWEEN ONSET AND DEATH   |                                  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |   |  |                                  |
| <b>420.1</b><br>IMMEDIATE CAUSE   |   | <b>24 HOURS</b>  |                                  |
| ANTECEDENT CAUSE (S)  |   | <b>UNKNOWN</b>   |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |   |  |                                  |
| (A) <b>INFARCTION OF MYOCARDIUM</b>   |   |  |                                  |
| DUE TO <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>   |   |  |                                  |
| (B)   |   |  |                                  |
| DUE TO  |   |  |                                  |
| (C)   |   |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                 |   | <b>LEFT HEMIPARESES SECONDARY TO THROMBOSIS OF RIGHT MIDDLE CEREBRAL ARTERY</b>                      |                                  |
| 19A. DATE OF OPERATION  |   | 19B. MAJOR FINDINGS OF OPERATION   |                                  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |                                  |
| 21A. ACCIDENT WAS UNDERLY NG <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)    |   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                               |                                  |
| 21C. WHERE DID (City or town) (County) (State)  |   | 21D. HOW DID INJURY OCCUR?   |                                  |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work  |   |  |                                  |
| 21F. TIME (Month) (Day) (Year) (Hour) OF INJURY   |   |  |                                  |
| 22. I hereby certify that I attended the deceased from <b>JULY 15, 1955</b> , to <b>JULY 19, 1955</b> , from the causes and on the date stated above. |   |  |                                  |
| SIGNATURE <b>Francis G. Dickey</b>  |   | DATE SIGNED  |                                  |
| ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>   |   |  |                                  |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |   | DATE THEREOF <b>JUL 23/55</b>  |                                  |
| NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE CEMETERY</b>   |   | LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>                                  |                                  |
| DATE REC'D BY LOCAL REGISTRAR <b>7-21-55</b>  |   | REGISTRAR'S SIGNATURE <b>Harry H. Witzke</b>   |                                  |
| ADDRESS <b>4101 Edmondson Ave., Baltimore, Md.</b>  |   |  |                                  |



06412

MARYLAND

STATE DEPARTMENT OF HEALTH

6411

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH:<br>COUNTY <b>Baltimore</b><br>CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Carney</b><br>TOWN<br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>10013 Harford Road</b> |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <b>Maryland</b> COUNTY <b>Baltimore</b><br>CITY (If outside corporate limits, write RURAL and give nearest town) <b>Carney</b><br>TOWN<br>STREET ADDRESS (If rural, give location) <b>10013 Harford Road</b> |  |
| 3. NAME OF DECEASED (Type or Print)<br><b>Mr. Vernon B. Richards</b>   |                                  | 4. DATE OF DEATH<br>(Month) <b>July</b> (Day) <b>23rd</b> (Year) <b>1955</b>   |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>wid</b>  | 8. DATE OF BIRTH<br><b>Apr. 2, 1909</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE last birthday<br><b>46</b> yrs. If under 1 year: Months   Days   Hours   Min. |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Mr. Emmitt H. Richards</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Minnie A. Bosse</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)  |                                  | 16. SOCIAL SECURITY No.<br><b>214-01-9838</b>  |  |
| 17. INFORMANT AND ADDRESS<br><b>MR EMMITT H. Richards - same</b>   |                                  |  |  |

15. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**345X**  
Immediate cause (a) ... **Multiple Sclerosis**

Antecedent cause(s)

Diseases or conditions, if any, (b) ...  
giving rise to the above cause  
stating the underlying cause last (c) ...

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

INTERVAL BETWEEN  
ONSET AND DEATH**20 yrs.**

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 19a. DATE OF OPERATION<br><b>none</b>      |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)    |  | PLACE (Home, farm, factory, street, OF office bldg., etc.)  |  | (CITY OR TOWN) (COUNTY) (STATE)  |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?  |  |

22. I hereby certify that I attended the deceased from **Sept 15, 1936**, to **July 23, 1955**, that I last saw the deceased alive on **July 23, 1955**, and that death occurred at **11:50 p.m.**, from the causes and on the date stated above.

SIGNATURE **Emmett H. Richards** (Degree or title) ADDRESS **5005 medical building July 24, 1955** DATE SIGNED

|  |  |  |   |   |         |
|--|--|--|---|---|---------|
| 23. BURIAL, CREMATION REMOVAL (Specify)<br><b>Burial</b> |  | DATE<br><b>7-27-55</b>                             | NAME OF CEMETERY OR CREMATORY<br><b>London Park</b> | LOCATION (City, town, or county)<br><b>Bald Md</b>                    | (State) |
| DATE REC'D BY LOCAL REG.<br><b>28 Sept 1955</b>          |  | REGISTRAR'S SIGNATURE<br><b>Emmett H. Richards</b> |   | 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, 5305 Harford Road #14</b> |         |

MARGIN RESERVED FOR BINDING

Dr. George Shannon  
Medical Arts Bldg.  
SA 7 5746

11-11-46

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06413  
 6412 Item 9, File G185 2-15-55 et

CERTIFICATE OF DEATH

Reg. Dist. No.

32

|  |                               |   |                                       |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH <i>Baltimore</i><br>COUNTY <i>MT. Wilson</i> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <i>Mt. Wilson State Hosp.</i> LENGTH OF STAY (in this place) <i>15 days</i><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><i>02</i>                      |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <i>great Mills, Md.</i> COUNTY <i>St. Mary's</i><br>CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>188-2</i><br>STREET ADDRESS (If rural give location) |                                       |
| 3. NAME OF DECEASED (Type or Print)<br><i>Ridgell Alphonsus McHugh</i><br>LAST FIRST MIDDLE  |                               | 4. DATE (Month) (Day) (Year)<br>OF DEATH: <i>7 28 1955</i>  |                                       |
| 5. SEX<br><i>m</i>   | 6. COLOR OR RACE<br><i>wh</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):<br><i>married</i>  | 8. DATE OF BIRTH:<br><i>11-1-1889</i> |
| 9. AGE last birthday IF UNDER 1 YEAR<br><i>66</i> yrs.   |                               | 10. IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired):<br><i>farmer</i>  |                               | 10B. KIND OF BUSINESS OR INDUSTRY:  |                                       |
| 11. BIRTHPLACE (State or foreign country):<br><i>great Mills</i>   |                               | 12. CITIZEN OF WHAT COUNTRY?  |                                       |
| 13. FATHER'S NAME:<br><i>Macu Ridgell</i>  |                               | 14. MOTHER'S MAIDEN NAME:<br><i>Georgiana Ferraro</i>   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)<br><i>no</i>  |                               | 16. SOCIAL SECURITY NO  |                                       |
| 17. INFORMANT & ADDRESS:<br><i>Mt. Wilson St. Hosp. Hospital Records, Mt. Wilson, Md.</i>  |                               |   |                                       |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><i>CC EX</i><br>IMMEDIATE CAUSE<br>ANTECEDENT CAUSE (S)<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |                               | 18. MEDICAL CERTIFICATION<br>(A) <i>far advanced pulmonary tuberculosis</i><br>DUE TO<br>(B) <i>spontaneous pneumothorax</i><br>DUE TO<br>(C)   |                                       |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                               | INTERVAL BETWEEN ONSET AND DEATH  |                                       |
| 19A. DATE OF OPERATION:  |                               | 19B. MAJOR FINDINGS OF OPERATION  |                                       |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                               |   |                                       |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)  |                                       |
| 21C. WHERE OLD (City or town) (County) (State)<br>INJURY OCCUR?  |                               |   |                                       |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br>M.  |                               | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                                       |
| 21F. HOW OLD INJURY OCCUR?   |                               |   |                                       |
| 22. I hereby certify that I attended the deceased from <i>19 54 2 PM</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>54 2 PM</i> , 19 <i>55</i> , and that death occurred at <i>54 2 PM</i> , from the causes and on the date stated above.<br>SIGNATURE <i>William Newman</i> M. O. ADDRESS DATE SIGNED |                               |   |                                       |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>burial</i>  |                               | DATE THEREOF <i>7-31-55</i> NAME OF CEMETERY OR CREMATORY <i>Our Lady's</i> LOCATION (City, town, or county) <i>Leonardtown</i> (State) <i>MD</i>   |                                       |
| DATE REC'D BY LOCAL REGISTRAR<br><i>Aug 1 1955</i>   |                               | REGISTRAR'S SIGNATURE <i>Wm. C. Mattingly</i> 24. FUNERAL DIRECTOR ADDRESS <i>Leonardtown</i>   |                                       |

MORQUE

06414

MARYLAND

STATE DEPARTMENT OF HEALTH

6413

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>COUNTY <u>Baltimore Co.</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>MD.</u> COUNTY                                  |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Cockeysville, Md.</u>   |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>         |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>Offutt Memorial Home</u>  |                                  | STREET ADDRESS (If rural, give location)<br><u>307 Lake Ave.</u>                                  |   |
| 3. NAME OF DECEASED<br>(Type or Print) (First) (Middle) (Last)<br><u>Olivia Stansbury Roberts</u>   |                                  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>July 2 1955</u>                                       |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>Widow</u>                                  | 8. DATE OF BIRTH<br><u>August 23 1875</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HW</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Housewife</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Joseph Kimberly</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Alice Kimberly</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT AND ADDRESS<br><u>Mrs. Newton Sibley - Monkton</u>  |                                  |   |   |
| 18. MEDICAL CERTIFICATION   |                                  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><u>420.1</u><br>Immediate cause (a) <u>Coronary Occlusion</u><br>Antecedent cause(s) (b).... <u>Arteriosclerosis</u><br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).... |                                  | <u>2 weeks</u><br><u>over 2</u><br><u>years</u>   |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |                                  |   |   |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>   |                                  |   |   |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)   |                                  | PLACE (Home, farm, factory, street, office bldg., etc.)   |   |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |   |
|   |                                  | HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <u>March</u> , 19 <u>53</u> , to <u>July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>55</u> , and that death occurred at <u>12 Noon</u> , from the causes and on the date stated above.     |                                  |   |   |
| SIGNATURE <u>Walter T. Kees</u>   |                                  | ADDRESS <u>Cockeysville Md.</u>   |   |
| 23. BURIAL, CREMATION REMOVAL (Specify)<br><u>Burial</u>  |                                  | DATE<br><u>July 5, 1955</u>   |   |
| NAME OF CEMETERY OR CREMATORY<br><u>Lorraine Park</u>   |                                  | LOCATION (City, town, or county) (State)<br><u>Woodlawn, Md.</u>                                  |   |
| DATE RECD BY LOCAL REGISTRAR'S SIGNATURE<br><u>5-55</u>   |                                  | 24. FUNERAL DIRECTOR<br><u>John O. Mitchell &amp; Sons Inc.</u>                                   |   |
|   |                                  | ADDRESS<br><u>1900 Eutaw Pl</u>   |   |

MARGIN RESERVED FOR BINDING





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06415

6414

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH-<br>COUNTY <u>Fuller</u> MARYLAND   |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Md.</u> COUNTY <u>Fuller</u>                                |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>X</u> TOWN <u>Redgers Forge</u>         |                               | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Redgers Forge</u> <u>X</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>240 Stanmore Rd</u>  |                               | STREET ADDRESS (If rural, give location)<br><u>240 Stanmore Rd</u>   |   |
| 3. NAME OF DECEASED<br>(Type or Print)  | (First) <u>Louise</u>         | (Middle) <u>Dozier</u>   | (Last) <u>Dozier</u>  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH <u>Aug 14, 1900</u> <u>CE</u> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Domestic Help</u> |                               | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE last birthday <u>55</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min. |
| 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u>   |                               | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><u>John Dozier</u>   |                               | 14. MOTHER'S MAIDEN NAME<br><u>May R. Hallock</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)            |                               | 16. SOCIAL SECURITY NO.<br><u>218-32-3990</u>  |   |
| 17. INFORMANT AND ADDRESS<br><u>Elizabeth C. Dozier 24 Stanmore Rd.</u>   |                               |  |   |

### 18. MEDICAL CERTIFICATION

|  |  |                                  |
|--|--|----------------------------------|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH |
| (a) <u>443X</u><br>Immediate cause<br><u>Hypertension - Cardiac Hypertrophy</u>  |  |                                  |
| (b) <u>Hemiplegia Complete Rt. side</u><br>Antecedent cause(s)<br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last |  |                                  |
| (c) <u>Arterio Sclerosis</u>   |  |                                  |

|   |  |  |
|---|--|--|
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY!<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT (Specify)<br>SUICIDE<br>HOMICIDE   | PLACE (Home, farm, factory, street, OF office bldg., etc.)<br>INJURY                                 | (CITY OR TOWN) (COUNTY) (STATE)  |
| TIME (Month) (Day) (Year) (Hour)<br>OF INJURY   | INJURY OCCURRED<br>While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR?  |

22. I hereby certify that I attended the deceased from July 10, 1955, to July 13, 1955, that I last saw the deceased alive on July 13, 1955, and that death occurred at 2:30 p.m., from the cause and on the date stated above.

SIGNATURE Louise C. Dozier (Degree or title) M.D. ADDRESS 6805 York Rd. DATE SIGNED 7/14/55

|   |  |  |   |
|---|--|--|---|
| 23. BURIAL CREMATION REMOVAL (Specify)<br><u>Burial</u> | DATE THEREOF<br><u>7-16-1955</u>             | NAME OF CEMETERY OR CREMATORY<br><u>Western</u>                    | LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u> |
| DATE REG'D BY LOCAL REG.<br><u>7-15-55</u>              | REGISTRAR'S SIGNATURE<br><u>A.W. Hedrich</u> | 24. FUNERAL DIRECTOR<br><u>G. Howard Strong 3207 W. North Ave.</u> |   |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6415

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH:   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                   |  |
| COUNTY <b>Balto.</b>   | MARYLAND   | STATE <b>Md.</b>   | COUNTY <b>Balto.</b>                       |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   | LENGTH OF STAY (in this place)   | CITY (If outside corporate limits, write RURAL and give nearest town) OR | TOWN                                       |
| TOWN <b>Hampton Village</b>  |  | TOWN <b>Hampton Village</b>  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |  | STREET ADDRESS (If rural give location)                                  |  |
| <b>559 Valley View Rd.</b>   |  | <b>559 Valley View Rd.</b>   |  |
| 3. NAME OF DECEASED:   |  | 4. DATE (Month) (Day) (Year)   |  |
| (Type or Print)  | First (Middle) (Last)  | OF DEATH   |  |
| <b>GEORGIANA E. ROLLE</b>  |  | <b>July 12, 1955</b>   |  |
| 5. SEX   | 6. COLOR OR RACE   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):                        | 8. DATE OF BIRTH:                          |
| <b>female</b>  | <b>white</b>   | <b>widowed</b>   | <b>July 20, 1863</b>                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):   |  | 10B. KIND OF BUSINESS OR INDUSTRY:                                       | 11. BIRTHPLACE (State or foreign country): |
| <b>housewife</b>   |  | <b>at home</b>   | <b>Maryland</b>                            |
| 13. FATHER'S NAME:   |  | 14. MOTHER'S MAIDEN NAME.  |  |
| <b>James McCall</b>  |  | <b>Unknown</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  |
| <b>no</b>  |  | <b>none</b>  |  |
| 17. INFORMANT & ADDRESS  |  |  |  |
| <b>Mrs. Maurice J. Keese-559 Valley View Rd</b>  |  |  |  |
| 18. MEDICAL CERTIFICATION  |  |  | INTERVAL BETWEEN ONSET AND DEATH           |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |
| 422.1 IMMEDIATE CAUSE  |  |  |  |
| (A) <b>Cardiovascular disease</b>  |  |  | <b>3 yrs</b>                               |
| ANTECEDENT CAUSE (S):  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST   |  |  |  |
| (B) <b>Advanced arterio sclerosis</b>  |  |  | <b>9</b>                                   |
| (C)  |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION   |  |
| <b>7-11-55</b>   |  |  |  |
| 20. AUTOPSY?   |  |  |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   | 21B. PLACE (Home, farm, factory, street, office bldg., etc.)   | 21C. WHERE DID INJURY OCCUR?   | (City or town) (County) (State)            |
|  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | 21F. HOW DID INJURY OCCUR?   |  |
|  |  |  |  |
| 22. I hereby certify that I attended the deceased from Jan 1, 1952, to July 12, 1955, that I last saw the deceased alive on July 11, 1955, and that death occurred at 8 A M, from the causes and on the date stated above. |  |  |  |
| SIGNATURE  |  | DATE SIGNED  |  |
| <b>Dr. J. J. Keese</b>   |  | <b>7/15/55</b>   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | NAME OF CEMETERY OR CREMATORY  |  |
| <b>Burial</b>  |  | <b>Western Cmn.</b>  |  |
| DATE REC'D BY LOCAL REGISTRAR  |  | LOCATION (City, town, or county) (State)                                 |  |
| <b>7/15/55</b>   |  | <b>Balto., Md.</b>   |  |
| REGISTRAR'S SIGNATURE  |  | FUNERAL DIRECTOR'S ADDRESS   |  |
| <b>Dr. J. J. Keese</b>   |  | <b>2220 Harrison Blvd. Md.</b>   |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



06417

MARYLAND

STATE DEPARTMENT OF HEALTH

6416

CERTIFICATE OF DEATH

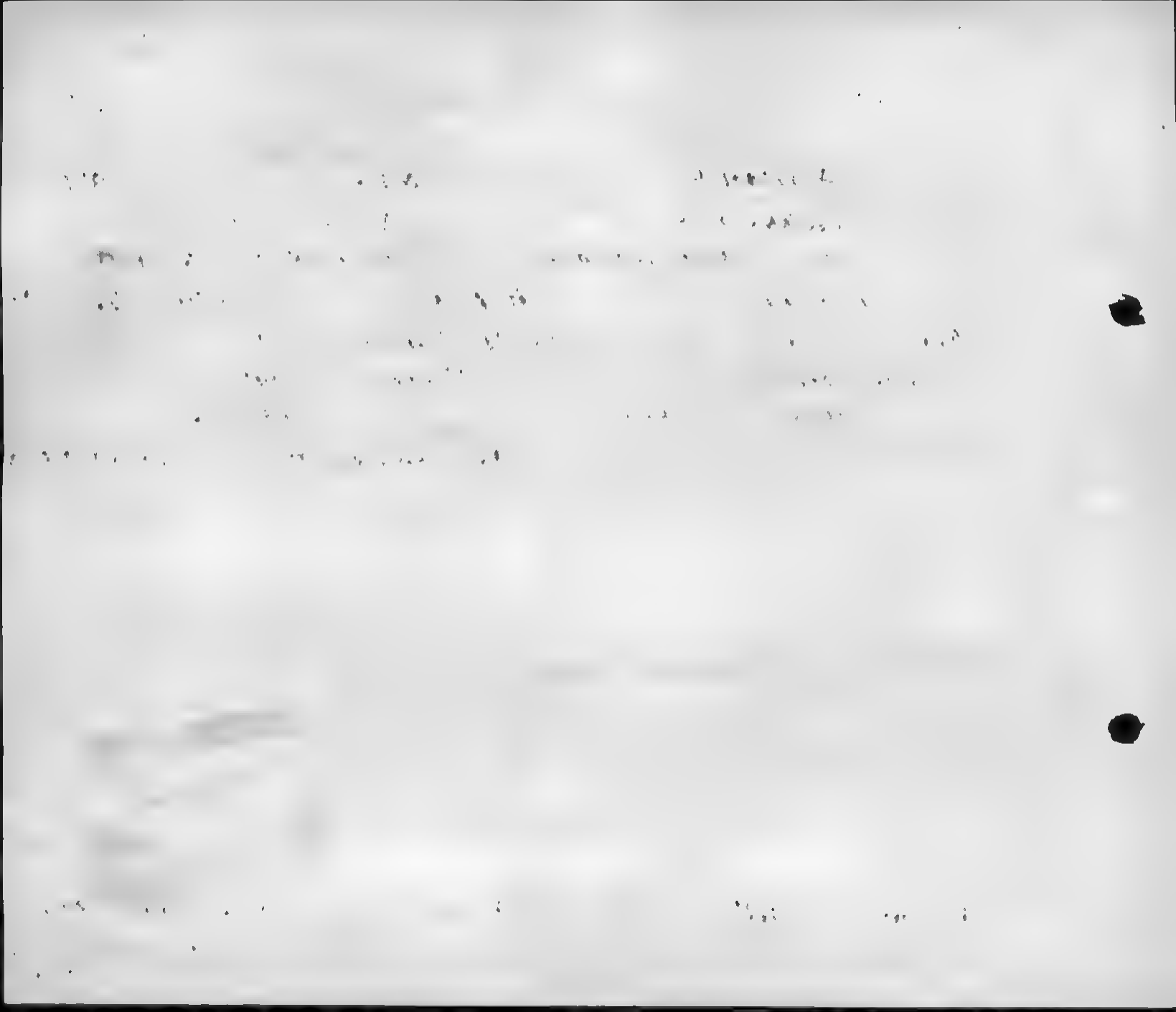
Reg. Dist. No. 30

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH-<br>COUNTY <b>BALTIMORE</b> MARYLAND  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <b>MD.</b> COUNTY <b>BALTO.</b>                   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>  |  | CITY (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>          |  |
| TOWN <b>52</b>  |  | TOWN <b>52</b>  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>804 FREDERICK AVE</b>  |  | STREET ADDRESS (If rural, give location) <b>804 FREDERICK AVE</b>                                 |  |
| 3. NAME OF DECEASED (First) <b>CHRISTIE</b> (Middle) <b>RUARK</b> (Last) <b>RUARK</b>   |  | 4. DATE OF DEATH (Month) <b>JULY</b> (Day) <b>7</b> (Year) <b>1955</b>                            |  |
| 5. SEX <b>M.</b>  |  | 6. COLOR OR RACE <b>W.</b>  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOWER</b>   |  | 8. DATE OF BIRTH <b>FEB. 19, 1886</b>   |  |
| 9. AGE last birthday <b>69</b> yrs.   |  | 10. If under 1 year Months Days Hours Min.  |  |
| 11a. USUAL OCCUPATION (Give kind of work done during past 12 months, if any) <b>CARPENTER</b>   |  | 11b. KIND OF BUSINESS OR INDUSTRY   |  |
| 12. BIRTHPLACE (State or foreign country) <b>HOOPERS ISLAND</b>   |  | 13. CITIZEN OF WHAT COUNTRY?  |  |
| 14. FATHER'S NAME <b>JAMES RUARK</b>  |  | 15. MOTHER'S MAIDEN NAME <b>LEWIS</b>   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)   |  | 17. SOCIAL SECURITY No.   |  |
| 18. INFORMANT AND ADDRESS <b>MRS William UHL, 429 S. PULASKI ST.</b>  |  |   |  |
| 18. MEDICAL CERTIFICATION<br>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><b>420.1</b><br>Immediate cause (a).....<br>Antecedent cause(s) (b).....<br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)..... |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |   |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)   |  | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY                                 |  |
| (CITY OR TOWN)  |  | (COUNTY)  |  |
| (STATE)   |  |   |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  |
| HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.   |  |   |  |
| SIGNATURE   |  | ADDRESS   |  |
| DATE SIGNED   |  |   |  |
| 23. BURIAL, CREMATION, REPOVAL (Specify) <b>BURIAL</b>  |  | DATE <b>JULY 11/55</b>  |  |
| NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN</b>   |  | LOCATION (City, town, or county) (State) <b>GLEN BURNIE MD.</b>                                   |  |
| DATE REC'D BY LOCAL REG. <b>7/11/55</b>   |  | REGISTRAR'S SIGNATURE <b>T.E. Harry</b>   |  |
| 24. FUNERAL DIRECTOR <b>Harry H. Wight</b>  |  | ADDRESS <b>1101 EDMONDSON AVE.</b>  |  |

MARGIN RESERVED FOR BINDING

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06419

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

6417

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH-<br>COUNTY <u>Baltimore</u>  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Md.</u> COUNTY                      |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>52 TOWN Baltimore</u>        |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>3001-4</u> |   |
| HOSPITAL OR<br>INSTITUTION OR<br>STREET ADDRESS <u>St. Smithwell Ave.,</u>                               |                                  | STREET ADDRESS (If rural, give location)<br><u>3029 H 1 1 Ave.,</u>                    |   |
| 3. NAME OF DECEASED<br>(Type or Print)   |                                  | 4. DATE OF DEATH   |   |
| (First) <u>John</u> (Middle) <u>L.</u> (Last) <u>Ruliger</u>   |                                  | (Month) <u>July</u> (Day) <u>13</u> (Year) <u>1955</u>                                 |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED.<br>(Specify) <u>Single</u>                      | 8. DATE OF BIRTH<br><u>June 12, 1903</u>                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)              |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE last birthday<br><u>52</u> yrs. If under 1 year Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><u>Charles R. Ruliger</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth May Ruliger</u>                               |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) |                                  | 16. SOCIAL SECURITY No.<br><u>016-03-218</u>   |   |
| 17. INFORMANT AND ADDRESS<br><u>Alice V. Puliger 3029 Hurler Ave.,</u>                                   |                                  |  |   |

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

44-  
Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

## 20. AUTOPSY?

Yes ☐ No ☒ (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 5, 1955, to July 13, 1955, that I last saw the deceasedalive on July 12, 1955, and that death occurred at 11:26 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7-15-55

A.F. Hedrich

dmr.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12



06419

MARYLAND

STATE DEPARTMENT OF HEALTH

6263

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH-<br>COUNTY <b>BALTO.</b> MARYLAND  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <b>MD.</b> COUNTY <b>BALTO.</b>      |   |
| CITY (If outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b>   |  | CITY (If outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>4041 WILKENS AVE.</b>   |  | STREET ADDRESS (If rural, give location) <b>4041 WILKENS AVE.</b>                    |   |
| 3. NAME OF DECEASED<br>(First) <b>KATHERINE</b><br>(Type or Print)   | (Middle) <b>M.</b>   | (Last) <b>RUEHL</b>  | 4. DATE OF DEATH<br>(Month) <b>JULY</b> (Day) <b>30</b> (Year) <b>1953</b>                  |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>W</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED.<br>(Specify) <b>MARRIED</b>                   | 8. DATE OF BIRTH <b>MAY 1, 1883</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>                                    | 9. AGE last birthday <b>72</b> yrs. If under 1 year Months Days If under 24 hrs. Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <b>MD.</b>   |  | 12. CITIZEN OF WHAT COUNTRY <b>USA</b>   |   |
| 13. FATHER'S NAME <b>GEORGE A. SHAFFER</b>   |  | 14. MOTHER'S MAIDEN NAME <b>SABINA DLEMTLE</b>                                       |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)  |  | 16. SOCIAL SECURITY No.  |   |
| 17. INFORMANT AND ADDRESS <b>George C. Ruehl - 17 Langford Ave.</b>  |  |  |   |
| 15. MEDICAL CERTIFICATION  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |   |
| Immediate cause (a) <b>Acute cardiac failure</b>   |  |  |   |
| Antecedent cause(s) (b) <b>Cancer of left ovary and breasts</b>  |  |  |   |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>None</b>   |  |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |  |  |   |
| 19a. DATE OF OPERATION <b>June 53</b>  | 19b. MAJOR FINDINGS OF OPERATION <b>Cancer lower breast + ovary</b>  |  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>            |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  | PLACE (Home, farm, factory, street, office bldg., etc.)  | (CITY OR TOWN)   | (COUNTY) (STATE)  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/> | HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <b>April 1953</b> to <b>July 30, 1953</b> , that I last saw the deceased alive on <b>July 30, 1953</b> and that death occurred at <b>11:30 P.M.</b> m., from the causes and on the date stated above. |  |  |   |
| SIGNATURE <b>George C. Ruehl</b>   |  | DATE SIGNED <b>July 31 1953</b>  |   |
| 23. BURIAL, CREMATION, REMOVAL (Specify)   | DATE <b>8-2-53</b>   | NAME OF CEMETERY OR CREMATORY <b>Greenwood Burial Co.</b>                            | LOCATION (City, town, or county) <b>Balto. Md.</b>  |
| DATE REC'D BY LOCAL REG.   | REGISTRAR'S SIGNATURE <b>George C. Ruehl</b>   | 24. FUNERAL DIRECTOR <b>George C. Ruehl - Catonsville, Md.</b>                       |   |

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MARYLAND

STATE DEPARTMENT OF HEALTH

6418

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>COUNTY <u>Baltimore</u> MARYLAND  |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Ma.</u> COUNTY <u>Balto.</u>                               |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>X</u> TOWN <u>Annapolis</u> LENGTH OF STAY (In this place) <u>4 days</u> |                               | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Cockeyville</u> <u>X</u> |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor</u>   |                               | STREET ADDRESS (If rural, give location) <u>Sherwood Road</u>  |  |
| 3. NAME OF DECEASED (Type or Print) (First) <u>Charles</u> (Middle) <u>Andrew</u> (Last) <u>Sarna</u>  |                               | 4. DATE OF DEATH (Month) <u>July</u> (Day) <u>5</u> (Year) <u>1955</u>                                       |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>  | 8. DATE OF BIRTH <u>Oct 22, 1873</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>executive Shred-Dicken</u>                            |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing</u>   | 9. AGE last birthday <u>81</u> yrs. If under 1 year: Months <u>1</u> Days <u>5</u> Hours <u>1</u> Min. |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>James Sarna</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Mary Svenson</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>NO</u> <u>NONE</u>                      |                               | 16. SOCIAL SECURITY No. <u>212-10-9525</u>   |  |
| 17. INFORMANT AND ADDRESS <u>records - College Manor</u>   |                               |  |  |

|  |  |  |
|--|--|--|
| 18. MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>years.</u>                        |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |
| <p>4221<br/>Immediate cause (a) <u>Anteriosclerotic Cardio-vascular disease</u></p> <p>Antecedent cause(s) (b) <u>giving rise to the above cause stating the underlying cause last</u></p> <p>(c) <u>---</u></p> |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |  |  |
| 19a. DATE OF OPERATION   | 19b. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT (Specify)<br>SUICIDE<br>HOMICIDE  | PLACE (Home, farm, factory, street, office bldg., etc.)<br>INJURY                                    | (CITY OR TOWN) (COUNTY) (STATE)  |
| TIME (Month) (Day) (Year) (Hour)<br>OF INJURY  | INJURY OCCURRED<br>While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR?  |

22. I hereby certify that I attended the deceased from Sept, 1954, to July 5, 1955, that I last saw the deceased alive on July 5, 1955, and that death occurred at 8:17 p. m., from the causes and on the date stated above.

SIGNATURE Elizabeth B. Stenill M.D. ADDRESS Cockeyville Md. DATE SIGNED 7/5/55

|  |  |   |   |
|--|--|---|---|
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | DATE <u>July 8, 1955</u>                 | NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Catholic Cem.</u> | LOCATION (City, town, or county) (State) <u>Cockeyville, Balto. Co. Md.</u> |
| DATE REC'D BY LOCAL REG. <u>25 July 1955</u>           | REGISTRAR'S SIGNATURE <u>Anna Harris</u> | 24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>       | ADDRESS   |

MARGIN RESERVED FOR BINNING

1955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6255

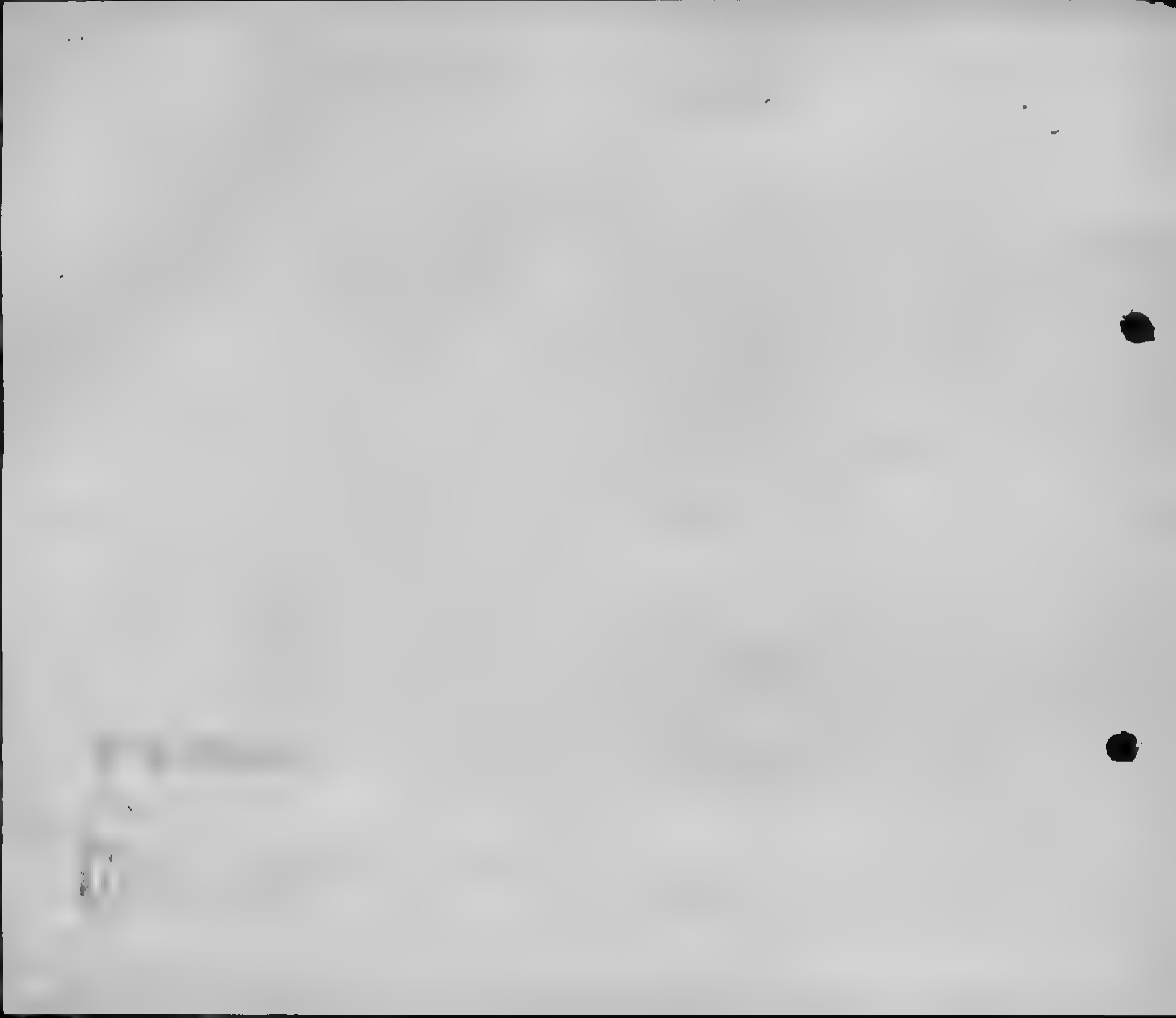
06421

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 41

|   |                                |   |  |   |   |   |                             |
|---|--------------------------------|---|--|---|---|---|-----------------------------|
| 1. PLACE OF DEATH:  |                                |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |   |   |                             |
| COUNTY <u>Balto</u>   |                                | MARYLAND  |  | STATE <u>Md</u>   |   | COUNTY <u>Balto</u>   |                             |
| CITY (If outside corporate limits, write TOWN OR and give nearest town) <u>Dundalk 22</u>   |                                | LENGTH OF STAY (in this place) <u>12 yrs</u>          |  | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Dundalk 22 Md.</u>                |   |   |                             |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Merritt Pt. Bathing Beach</u>  |                                |   |  | STREET ADDRESS (If rural, give location) <u>7521 Halaburd ave</u>   |   |   |                             |
| 3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>James Garrett Sacra II</u>  |                                |   |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>July 17 1955</u>   |   |   |                             |
| 5. SEX: <u>Male</u>   | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, OR FORCED: <u>Single</u> | 8. DATE OF BIRTH: <u>JULY 24, 1940</u> | 9. AGE last birthday: <u>14</u> yrs.  | IF UNDER 1 YEAR: Months Days Hours Min. |   | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>STUDENT</u>  |                                | 10b. KIND OF BUSINESS OR INDUSTRY:                    |  | 11. BIRTHPLACE (State or foreign country): <u>VIRGINIA</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>                    |                             |
| 13. FATHER'S NAME: <u>JAMES G. SACRA II</u>   |                                |   |  | 14. MOTHER'S MAIDEN NAME: <u>VIRGINIA E. ROACH</u>  |   |   |                             |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NU</u>  |                                | (If Yes, give war or dates of service)                |  | 16. SOCIAL SECURITY No.: <u>NONE</u>  |   | 17. INFORMANT & ADDRESS: <u>JAMES G. SACRA II - SAME RES.</u>   |                             |
| 18. MEDICAL CERTIFICATION   |                                |   |  |   |   |   |                             |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>727.8 Immediate cause</u>   |                                |   |  | (a) ... <u>Drowning (accidental)</u>  |   |   |                             |
| Antecedent cause(s) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>   |                                |   |  | (b) ... <u>DUE TO</u>   |   |   |                             |
| 19. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:   |                                |   |  |   |   |   |                             |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                |   |  | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY  |   | 21c. (City or town) (County) (State)                            |                             |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 17 1955 6:10 P.M.</u>   |                                |   |  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR? <u>Bathing beach drowning</u>        |                             |
| 22. I hereby certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                |   |  |   |   |   |                             |
| SIGNATURE <u>R. M. J. Armine MD</u>   |                                |   |  | DATE SIGNED <u>July 19-1955</u>   |   |   |                             |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>   |                                | DATE THEREOF <u>7-20-55</u>                           |  | NAME OF CEMETERY OR CREMATORY <u>FR LAWN</u>  |   | LOCATION (City, town, or county) (State) <u>BALTO. CO., MD.</u> |                             |
| DATE REC'D BY LOCAL REG. <u>July 19-1955</u>  |                                |   |  | 24. FUNERAL DIRECTOR <u>William M Kelly White &amp; Brady, Dundalk 22, Md.</u>                                    |   |   |                             |



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06422

6419

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

|  |  |  |                               |
|--|--|--|-------------------------------|
| 1. PLACE OF DEATH:   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                               |
| COUNTY <u>Balto.</u>   | MARYLAND                                     | STATE <u>Md.</u>   | COUNTY <u>Pr. Geo.</u>        |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 TOWN EATONSVILLE</u>  | LENGTH OF STAY (in this place) <u>2 yrs.</u> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hyattsville, Md.</u>  |                               |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>  |  | STREET ADDRESS (If rural give location) <u>5408 13th Ave.</u>  |                               |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |  | 4. DATE (Month) (Day) (Year) OF DEATH:   |                               |
| <u>Hannah Barbara Sakers</u>   |  | <u>7-3-55 19</u>   |                               |
| 5. SEX: <u>F</u>   | 6. COLOR OR RACE: <u>W</u>                   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  | 8. DATE OF BIRTH: <u>1875</u> |
| 9. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.  |  | 10. BIRTHPLACE (State or foreign country):   |                               |
| <u>80 yrs.</u>   |  | <u>District of Columbia USA</u>  |                               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>  |  | 10B. KIND OF BUSINESS OR INDUSTRY:   |                               |
| 13. FATHER'S NAME: <u>Charles Heitmuller</u>   |  | 14. MOTHER'S MAIDEN NAME: <u>Hannah Bootstein</u>  |                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |                               |
|  |  | 17. INFORMANT & ADDRESS: <u>JOHN HEITMULLER 5408-13th AVE. HYATTSVILLE, MD.</u>  |                               |
| 18. MEDICAL CERTIFICATION  |  |  |                               |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |                               |
| IMMEDIATE CAUSE <u>4221</u>  |  | (A) DUE TO <u>cerebrovascular accident, left</u>   |                               |
| ANTECEDENT CAUSE (B):  |  | (B) DUE TO <u>arteriosclerotic cardio -</u>  |                               |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.   |  | (C) <u>vascular disease</u>  |                               |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |                               |
| 19A. DATE OF OPERATION:  |  | 19B. MAJOR FINDINGS OF OPERATION   |                               |
|  |  |  |                               |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.  |                               |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?   |  |  |                               |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                               |
|  |  | 21F. HOW DID INJURY OCCUR?   |                               |
| 22. I hereby certify that I attended the deceased from <u>4-29-55</u> to <u>7-3-55</u> , that I last saw the deceased alive on <u>7-3-55</u> , 19 <u>55</u> , and that death occurred <u>6:50 A</u> M, from the causes and on the date stated above. |  |  |                               |
| SIGNATURE <u>Harold Edwards M.D.</u>   |  | ADDRESS <u>Spring Grove State Hospital</u> DATE SIGNED <u>7-3-55</u>   |                               |
| 23. BURIAL, CREMATION, REMOVAL, (SPECIFY)  |  | DATE THEREOF   |                               |
| <u>Burial</u>  |  | <u>July 5, 1955</u>  |                               |
| NAME OF CEMETERY OR CREMATORY  |  | LOCATION (City, town, or county) (State)   |                               |
| <u>Glenwood Cemetery</u>   |  | <u>Washington, D.C.</u>  |                               |
| DATE REC'D BY LOCAL REGISTRAR  |  | REGISTRAR'S SIGNATURE  |                               |
| <u>July 4, 1955</u>  |  | <u>Blw Lammann</u>   |                               |
| FUNERAL DIRECTOR   |  | ADDRESS  |                               |
| <u>Arthur J. Hall</u>  |  | <u>254 Carroll ST NW WASHINGTON, D.C.</u>  |                               |





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| 6420  |  |                                    |  | 07514  |  |   |  |
|---|--|------------------------------------|--|--|--|---|--|
| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |  |                                    |  |  |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 30  |  |                                    |  |  |  |   |  |
| 1. PLACE OF DEATH:  |  |                                    |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |   |  |
| COUNTY <b>Baltimore</b>   |  | MARYLAND                           |  | STATE <b>Maryland county Anne Arundel Co.</b>  |  |   |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  |  | LENGTH OF STAY (in this place)     |  | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN                           |  |   |  |
| TOWN <b>Baltimore-Catonsville</b>   |  | <b>5 days</b>                      |  | TOWN <b>Unknown</b>  |  |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spring Grove State Hospital Baltimore 28, Maryland</b>   |  |                                    |  | STREET ADDRESS (If rural, give location) <b>Unknown</b>  |  |   |  |
| 3. NAME OF DECEASED: (Type or Print)  |  | (First)                            |  | (Middle)   |  | (Last)                                    |  |
| <b>Hugo</b>   |  |                                    |  | <b>Schaivale</b>   |  |   |  |
| 4. DATE OF DEATH  |  | (Month)                            |  | (Day)  |  | (Year)                                    |  |
| <b>July</b>   |  | <b>26</b>                          |  | <b>1955</b>  |  |   |  |
| 5. SEX:   |  | 6. COLOR OR RACE:                  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  |  | 8. DATE OF BIRTH:                         |  |
| <b>Male</b>   |  | <b>White</b>                       |  | <b>Single</b>  |  | <b>Unknown</b>                            |  |
| 9. AGE last birthday:   |  | IF UNDER 1 YEAR                    |  | IF UNDER 24 HRS.   |  |   |  |
| <b>85</b> yrs.  |  | Months                             |  | Days   |  | Hours                                     |  |
|   |  |                                    |  |  |  | Min.                                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):   |  | 10b. KIND OF BUSINESS OR INDUSTRY: |  | 11. BIRTHPLACE (State or foreign country):   |  | 12. CITIZEN OF WHAT COUNTRY?              |  |
| <b>Unknown</b>  |  | <b>--</b>                          |  | <b>--</b>  |  |   |  |
| 13. FATHER'S NAME:  |  |                                    |  | 14. MOTHER'S MAIDEN NAME:  |  |   |  |
| <b>Unknown</b>  |  |                                    |  | <b>Unknown</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |  |                                    |  | 16. SOCIAL SECURITY No.:   |  | 17. INFORMANT & ADDRESS:                  |  |
| <b>Unknown</b>  |  |                                    |  | <b>--</b>  |  | <b>None-Spring Grove Hospital Records</b> |  |
| 18. MEDICAL CERTIFICATION   |  |                                    |  |  |  |   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  |  |                                    |  |  |  | INTERVAL BETWEEN ONSET AND DEATH          |  |
| 420. Immediate cause (a) Cardiac failure DUE TO   |  |                                    |  |  |  |   |  |
| Antecedent cause(s) (b) Arteriosclerotic heart disease DUE TO   |  |                                    |  |  |  |   |  |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Senility   |  |                                    |  |  |  |   |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Mental illness  |  |                                    |  |  |  |   |  |
| 19a. DATE OF OPERATION:   |  |                                    |  | 19b. MAJOR FINDING OF OPERATION:   |  |   |  |
|   |  |                                    |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |                                    |  | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY                                 |  | 21c. (City or town) (County) (State)      |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.  |  |                                    |  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?                |  |
|   |  |                                    |  |  |  |   |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |                                    |  |  |  |   |  |
| SIGNATURE   |  |                                    |  | CHIEF MEDICAL EXAMINER   |  | DATE SIGNED                               |  |
| <b>George Kieffer, M.D.</b>   |  |                                    |  | <b>10/10 T. Edwards</b>  |  | <b>7-27-55</b>                            |  |
|   |  |                                    |  | DEPUTY MEDICAL EXAMINER  |  |   |  |
|   |  |                                    |  | ASSISTANT MEDICAL EXAM.  |  |   |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify):   |  | DATE THEREOF                       |  | NAME OF CEMETERY OR CREMATORY  |  | LOCATION (City, town, or county) (State)  |  |
| <b>10/10 T. Edwards</b>   |  | <b>8/9/55</b>                      |  | <b>County Home</b>   |  | <b>Edgewood</b>                           |  |
| DATE REC'D BY LOCAL REG   |  | REGISTRAR'S SIGNATURE              |  | 24. FUNERAL DIRECTOR   |  | ADDRESS                                   |  |
| <b>8-8-55</b>   |  | <b>U.E. Harris</b>                 |  | <b>Barrett</b>   |  | <b>Parish</b>                             |  |

3 A EVI 15

408 11 1 55

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

6421

## 1. PLACE OF DEATH:

COUNTY Balto. MARYLAND  
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville LENGTH OF STAY (In this place)HOSPITAL OR INSTITUTION OR STREET ADDRESS Shady Nook Nursing Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Balto.  
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BaltimoreSTREET ADDRESS (If rural give location) 301 Cedarcroft Rd.

## 3. NAME OF DECEASED:

First (Middle) (Last)  
LINNIE ELIZABETH SCHISLER

## 5. SEX.

female

## 6. COLOR OR RACE

white

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED.

(Specify): Widowed

## 8. DATE OF BIRTH

Aug. 28, 1867

## 4. DATE (Month) (Day) (Year)

OF DEATH. July 18, 19 559. AGE last birthday IF UNDER 1 YEAR IF UNDER 6 HRS  
87 yrs Months Days Hours Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)

housewife

## 10B. KIND OF BUSINESS OR INDUSTRY:

at home

## 11. BIRTHPLACE (State or foreign country).

Md.

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

Ferdinand Scheffer

## 14. MOTHER'S MAIDEN NAME:

Catherine Rever

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

-

## 17. INFORMANT &amp; ADDRESS.

Mr. Herbert N. Schisler-301 Cedarcroft Rd.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

## IMMEDIATE CAUSE

(A)

arteriosclerotic cardiovascular disease

## INTERVAL BETWEEN ONSET AND DEATH

5 yrs

## ANTECEDENT CAUSE (S)

DUE TO

## DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, street, office bldg., etc.)

## 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 30, 1953, to 15 July, 1955, that I last saw the deceased alive on 18 July, 1955, and that death occurred at 4:05 P.M. from the causes and on the date stated above.

## SIGNATURE

John H. Hedrick

## ADDRESS

M D 418 St Paul St. Balt. 2, Md. 7-19-55

## DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

## DATE THEREOF

7/20/55

## NAME OF CEMETERY OR CREMATORY

Baltimore Cem.

## LOCATION (City, town, or county)

Balto., Md.

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

7/24/55 H. W. Hedrick

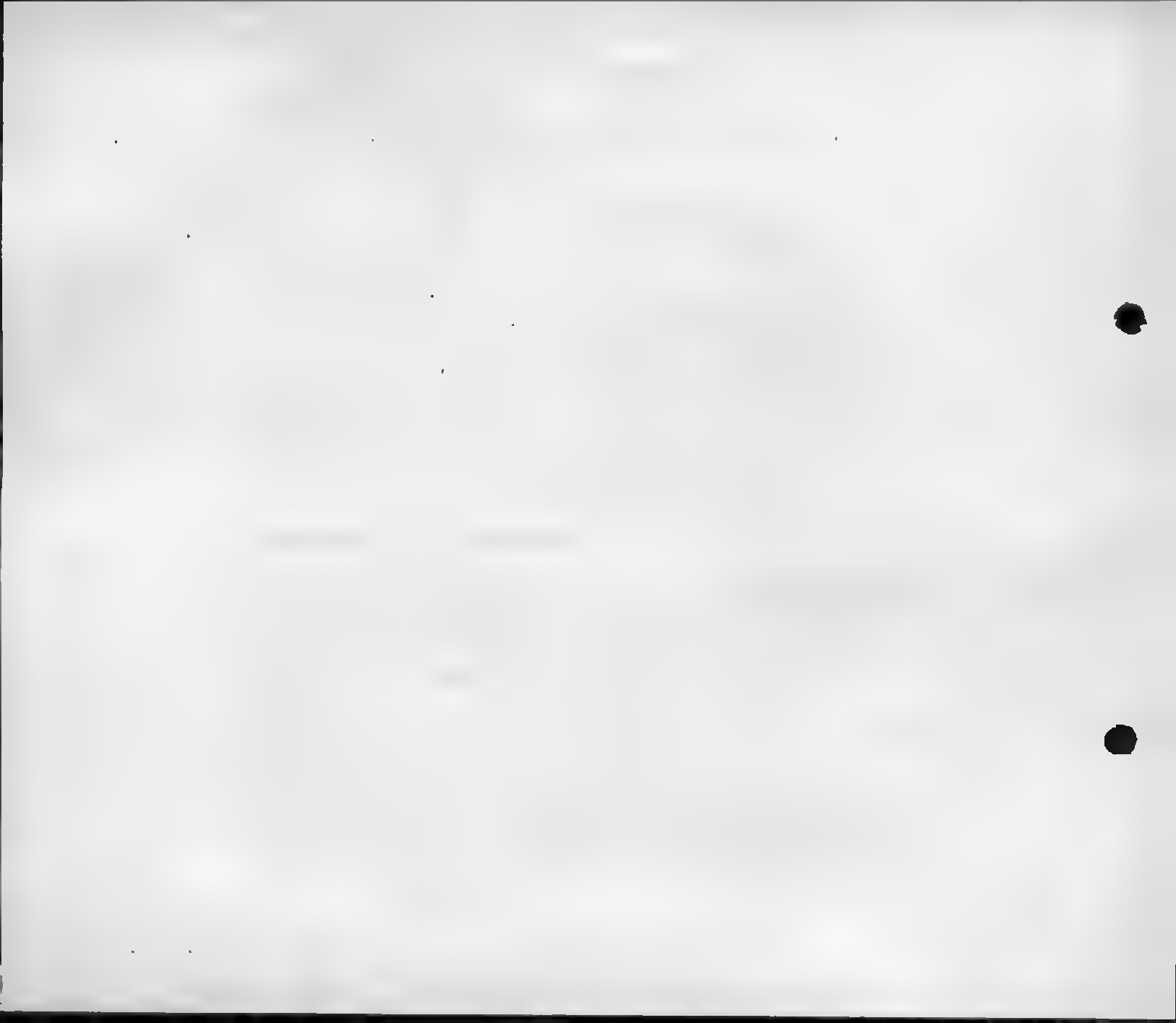
## FUNERAL DIRECTOR

## ADDRESS

John J. Schisler House - Balt 17 Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

6422

06424

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH-<br>COUNTY <u>Balto</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>md</u> COUNTY <u>Balto</u>   |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><input checked="" type="checkbox"/> TOWN <u>Baldwin</u> |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Baldwin</u> <input checked="" type="checkbox"/> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>Fork Rd.</u>   |                                  | STREET ADDRESS (If rural, give location)<br><u>Fork Rd</u>  |   |
| 3. NAME OF DECEASED<br>(Type or Print) <u>August P Schnabel</u>  |                                  | 4. DATE OF DEATH<br>(Month) <u>July</u> (Day) <u>19</u> (Year) <u>1955</u>  |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>   | 8. DATE OF BIRTH<br><u>Dec 19-1876</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Bricklayer</u>                 |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Owner own business</u>  | 9. AGE last birthday<br><u>78</u> yrs. If under 1 year: Months <u>7</u> Days <u>19</u> Hours <u>19</u> Min. <u>55</u> |
| 11. BIRTHPLACE (State or foreign country)<br><u>Germany</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>August F Schnabel</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth Meinschein</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>            |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |   |
| 17. INFORMANT AND ADDRESS<br><u>Mrs August P. Schnabel Fork Rd Baldwin md</u>  |                                  |   |   |

|   |                                  |
|---|----------------------------------|
| 18. MEDICAL CERTIFICATION                                   |                                  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH         | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause (a) <u>Cerebral Hemorrhage</u>              | <u>4 days</u>                    |
| Antecedent cause(s) (b) <u>Hypertensive Cardiovas. Dis.</u> | <u>5 yrs.</u>                    |
| (c) _____   |                                  |

|   |   |
|---|---|
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |   |
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)   | PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)                                 |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 3/6, 1953 to 7/19, 1955, that I last saw the deceased alive on 7/18, 1955, and that death occurred at 1:30 A m., from the causes and on the date stated above.

SIGNATURE Lifford F. Hudson ADDRESS M.D. Fork Md DATE SIGNED 7/20/55

|  |                       |                               |  |
|--|-----------------------|-------------------------------|--|
| 23. BURIAL CREMATION REMOVAL (Specify) | DATE THEREOF          | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| <u>Burial</u>                          | <u>7/21/55</u>        | <u>Belair n. Gardens</u>      | <u>Harfordco. Md</u>                     |
| DATE REC'D BY LOCAL REG.               | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR          | ADDRESS                                  |
| <u>7-20-55</u>                         | <u>Wm n Hamm</u>      | <u>Harfordco. Md</u>          | <u>7401 Belair Rd.</u>                   |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 2

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

6663

06425

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>COUNTY <u>BALTIMORE</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>MARYLAND</u> COUNTY                             |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>HAELETHORPE</u>  |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>BALTIMORE</u>    |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>5615 Oregon Ave</u>   |                                  | STREET ADDRESS (If rural, give location)<br><u>119 S. Fayson St</u>                               |  |
| 3. NAME OF DECEASED<br>(Type or Print)  | (First) <u>GERTRUDE</u>          | (Middle) <u>IRENE</u>   | (Last) <u>Schwartz</u>                       |
| 4. DATE OF DEATH  | (Month) <u>7</u>                 | (Day) <u>21</u>   | (Year) <u>1955</u>                           |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>                                   | 8. DATE OF BIRTH<br><u>Aug 14, 1895</u>      |
| 9. AGE last birthday<br><u>59</u> yrs.  |                                  | 10. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>                                      | 11. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u> |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                                  | 13. KIND OF BUSINESS OR INDUSTRY<br><u>Domestic</u>   |  |
| 14. FATHER'S NAME<br><u>HENRY SIECK</u>   |                                  | 15. MOTHER'S MARRIED NAME<br><u>Unknown</u>   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)<br><u>NO</u>  |                                  | 17. SOCIAL SECURITY NO.<br><u>NONE</u>  |  |
| 18. INFORMANT AND ADDRESS<br><u>Mr GEORGE W. Schwartz 5818 Windsor St</u>   |                                  |   |  |
| 18. MEDICAL CERTIFICATION   |                                  |   |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| Immediate cause<br><u>151X (a) Carcinoma of Stomach</u>   |                                  | <u>6 mo</u>   |  |
| Antecedent cause(s)<br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last<br>(b) _____<br>(c) _____   |                                  |   |  |
| 19. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |                                  |   |  |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION  |  |
| 20. ACCIDENT SUICIDE HOMICIDE (Specify)   |                                  | PLACE (Home, farm, factory, street, office bldg., etc.)   |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  |
|   |                                  | HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <u>1954</u> , 19... to <u>7/21, 1955</u> , that I last saw the deceased alive on <u>7/21, 1955</u> , and that death occurred at <u>6 P</u> m., from the causes and on the date stated above. |                                  |   |  |
| SIGNATURE<br><u>Edward N. Hallie MD 4300 Liberty Ave</u>  |                                  | DATE SIGNED<br><u>7/21/55</u>   |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | NAME OF CEMETERY OR CREMATORY   |  |
| DATE<br><u>7-25-55</u>  |                                  | <u>WESTERN</u>  |  |
| LOCATION (City, town, or county) (State)<br><u>BALTIMORE MD</u>   |                                  |   |  |
| DATE REC'D BY LOCAL REG.<br><u>7-25-55</u>  |                                  | 24. FUNERAL DIRECTOR<br><u>George L. Schmitt 2101 Frederick Ave</u>                               |  |
| REGISTRAR'S SIGNATURE<br><u>AW 16 Cuel</u>  |                                  | ADDRESS<br><u>Balto., Md.</u>   |  |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician please write the causes of death clearly and legibly.





6423

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) Lodge Forrest (19) 18 MONTHSTOWN Lodge Forrest (19)

HOSPITAL OR INSTITUTE OR STREET ADDRESS

7730 North Cove Road

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MarylandCOUNTY Balto.CITY (If outside corporate limits, write RURAL and give nearest town) Lodge Forrest (19) XTOWN Lodge Forrest (19)

STREET ADDRESS

7730 North Cove Road

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

CARSONCARROLLSEGELKEN

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

July 3rd,1955

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

If UNDER 1 YEAR

If UNDER 24 HRS

malewhitemarriedSept. 20, 188074

yrs.

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, (Specify):

General merchant

## 10b. KIND OF BUSINESS OR INDUSTRY:

retail store

## 11. BIRTHPLACE (State or foreign country)

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Carson J. Segelken

## 14. MOTHER'S MAIDEN NAME:

Metta Hendrick

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

no

## 16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)

---

## 17. INFORMANT &amp; ADDRESS:

7730 North Cove RoadMrs. M. EngbergLodge Forrest 19, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0  
Immediate cause(a) .. Auto. Coroner Inquesting  
DUE TO

## Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) .. Arteriosclerosis Heart Disease  
DUE TO

(c)

Interval Between Onset And Death

3 hrs2 yrs

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

m.

## INJURY OCCURRED

While at ☒ Not While At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1955, to June 3, 1955, that I last saw the deceasedalive on June 3, 1955, and that death occurred at 9:55 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

James T. MenaM.D.520 D St. Balt 19 Md7/4/55

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

WITNESSES

ADDRESS

July 5, 1955Lawson L. FarleyWalter Brooks Bradley, Inc., Dundalk, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1955

BUREAU V. E.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

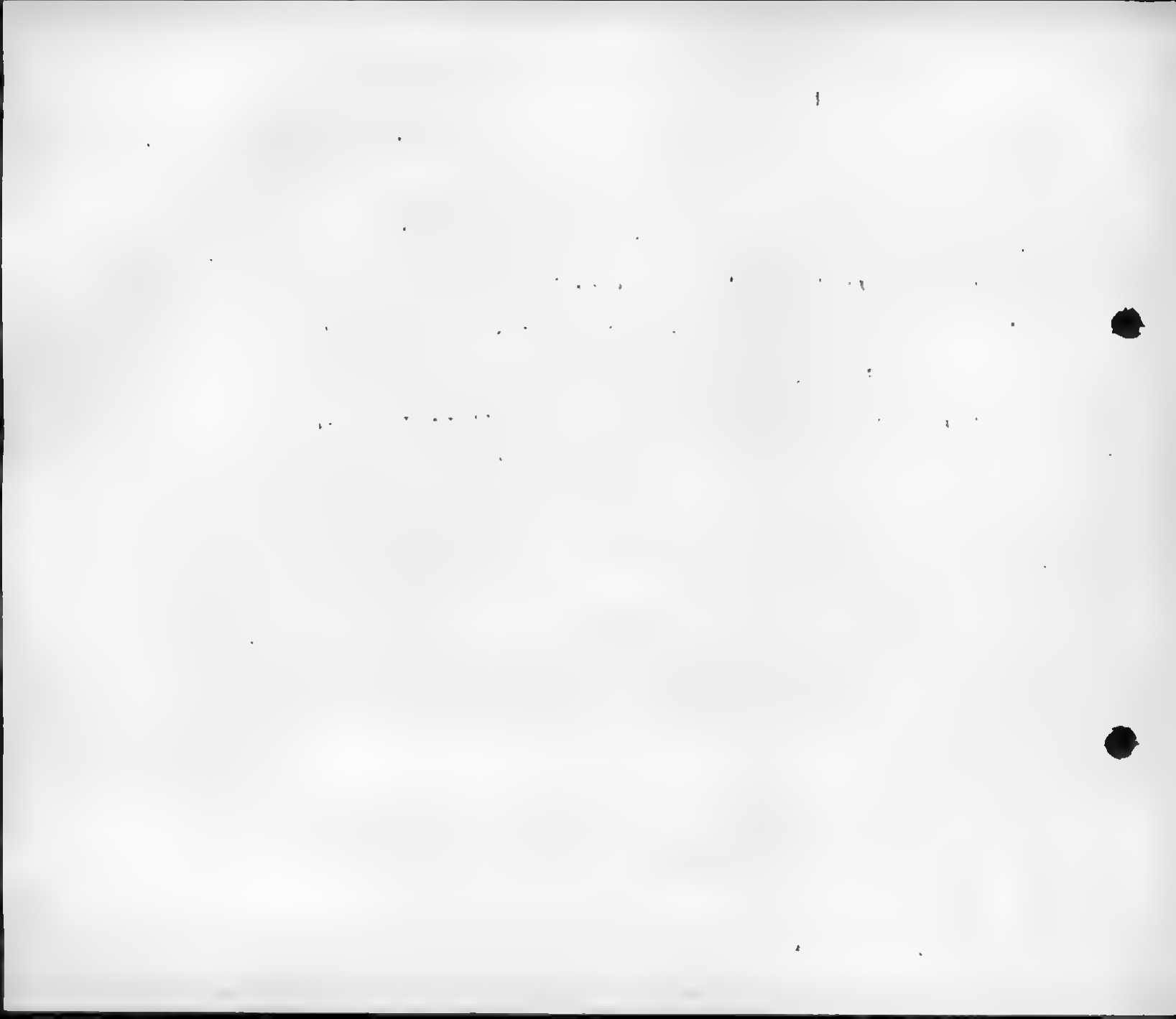
## 6424

### CERTIFICATE OF DEATH

Reg. Dist. No.

06/10/55

|   |                   |  |                    |
|---|-------------------|--|--------------------|
| 1. PLACE OF DEATH:  |                   | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                    |
| COUNTY <u>BALTO.</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u><br>OR TOWN <u>ESSEX</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 575 SUE GROVE RD.</u>   |                   | STATE <u>MD.</u> COUNTY <u>BALTO.</u><br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u><br>OR TOWN <u>ESSEX</u><br>STREET ADDRESS (If rural give location) <u>Box 575 SUE GROVE RD.</u>  |                    |
| 3. NAME OF DECEASED:  |                   | 4. DATE OF DEATH:  |                    |
| (Type or Print) <u>LYDIA SOPHIA SEIDLICH</u><br>(First) (Middle) (Last)   |                   | (Month) (Day) (Year)<br><u>JULY 25 1955</u>  |                    |
| 5. SEX:   | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  | 8. DATE OF BIRTH:  |
| <u>FEMALE</u>   | <u>WHITE</u>      | <u>WIDOWED</u>   | <u>OCT 6, 1890</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  |                   | 10B. KIND OF BUSINESS OR INDUSTRY:   |                    |
| <u>HOUSE WIFE</u>   |                   | <u>—</u>   |                    |
| 13. FATHER'S NAME:  |                   | 14. MOTHER'S MAIDEN NAME:  |                    |
| <u>JOHN NIES</u>  |                   | <u>MATILDA HOHN</u>  |                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)  |                   | 16. SOCIAL SECURITY NO.  |                    |
| <u>No</u>   |                   | <u>—</u>   |                    |
| 17. INFORMANT & ADDRESS:  |                   | 18. MEDICAL CERTIFICATION  |                    |
| <u>RUTH NUBERT 558 SUE GROVE RD.</u>  |                   | 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br>IMMEDIATE CAUSE (A) <u>Arterio-sclerotic Cardio-vascular lesions</u><br>ANTECEDENT CAUSE (B) <u>Coronary Thrombosis</u><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>—</u> |                    |
| 19A. DATE OF OPERATION:   |                   | 19B. MAJOR FINDINGS OF OPERATION   |                    |
| <u>no</u>   |                   | <u>—</u>   |                    |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                   | 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                    |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                    |
| 21C. WHERE DID (City or town) (County) (State)  |                   | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                    |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                   | 21F. HOW DID INJURY OCCUR?   |                    |
| 22. I hereby certify that I attended the deceased from <u>July 25, 1955</u> , to <u>July 25, 1955</u> ; that I last saw the deceased alive on <u>July 25, 1955</u> ; and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. |                   |  |                    |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                   | 24. FUNERAL DIRECTOR   |                    |
| <u>BURIAL</u>   |                   | <u>A. Christine Brzezinski 1407 Eastern Ave</u>  |                    |
| DATE REC'D BY LOCAL REGISTRAR <u>7-26-55</u>  |                   | REGISTERAR'S SIGNATURE <u>—</u>  |                    |
| DATE THEREOF <u>7/28/55</u>   |                   | NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>  |                    |
| LOCATION (City, town, or county) <u>Balto. Md.</u>  |                   | (State) <u>—</u>   |                    |



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

6425

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH-<br>COUNTY <u>Balto.</u> MARYLAND   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Md.</u> COUNTY <u>Balto.</u>                   |  |
| CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Raspeburg</u>   |  | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>            |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8513 Belair Road</u>   |  | STREET ADDRESS (If rural, give location) <u>8513 Belair Road</u>                                  |  |
| 3. NAME OF DECEASED<br>(Type or Print) <u>HELEN SHESKA</u>  |  | 4. DATE OF DEATH <u>July 21, 1955</u>   |  |
| 5. SEX <u>female</u>  |  | 6. COLOR OR RACE <u>white</u>   |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>   |  | 8. DATE OF BIRTH <u>March 4, 1883</u>   |  |
| 9. AGE last birthday <u>72 yrs.</u>   |  | 10. If under 1 year Months Days Hours Min.  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Poland</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>  |  |
| 13. FATHER'S NAME <u>Andrew Balukevich</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  | 16. SOCIAL SECURITY No. <u>none</u>   |  |
| 17. INFORMANT AND ADDRESS <u>Mr. John F. Sheska, 8513 Belair Road, Balto.</u>   |  | 18. MEDICAL CERTIFICATION   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| Immediate cause (a) <u>Carcinoma of Rt Lung</u>   |  | <u>2 yrs.</u>   |  |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)  |  |   |  |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |   |  |
| 21. ACCIDENT (Specify) <u>SUICIDE</u>   |  | PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)        |  |
| HOMICIDE  |  | INJURY  |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> |  |
| HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>3/1</u> , 19 <u>55</u> , to <u>7/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/20</u> , 19 <u>55</u> , and that death occurred at <u>4:45 p.m.</u> , from the causes and on the date stated above. |  |   |  |
| SIGNATURE <u>R. J. Bettagh</u>  |  | DATE SIGNED <u>7/22/55</u>  |  |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>   |  | DATE THEREOF <u>7/25/55</u>   |  |
| NAME OF CEMETERY OR CREMATORY <u>St. Josephs Cemetery</u>   |  | LOCATION (City, town, or county) (State) <u>Belair Rd. Balto. Co., Md.</u>                        |  |
| DATE REC'D BY LOCAL REG. <u>7-24-55</u>   |  | REGISTERAR'S SIGNATURE <u>W. M. Hammett</u>   |  |
| FUNERAL DIRECTOR <u>Laurel Funeral Home</u>   |  | ADDRESS <u>7401 Belair Rd.</u>  |  |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

578

*[Faint, illegible markings]*

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06429

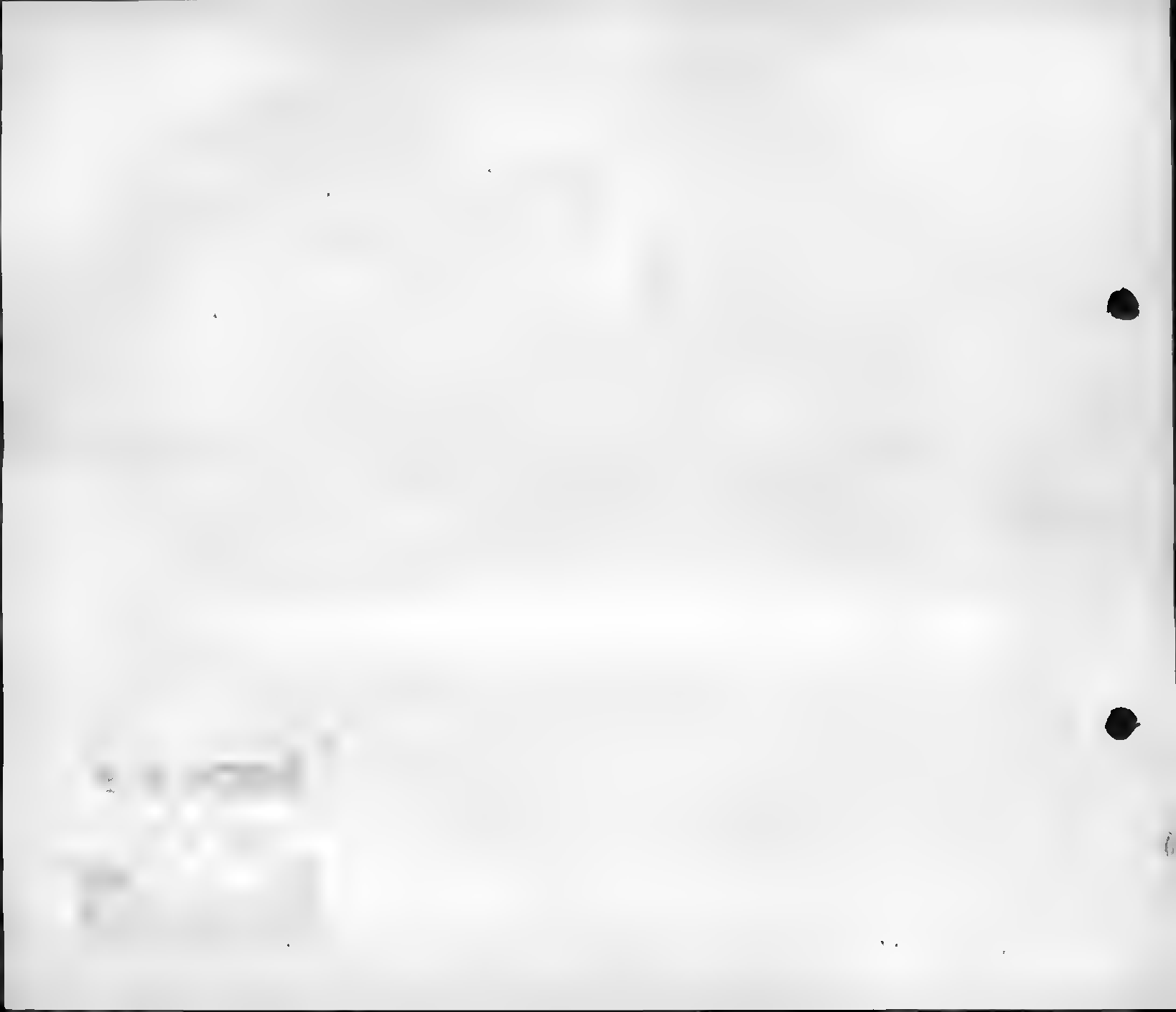
6426

Item 9, Film 183 7-13-55 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

|   |  |                                |  |  |  |                             |  |
|---|--|--------------------------------|--|--|--|-----------------------------|--|
| 1. PLACE OF DEATH:  |  |                                |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |                             |  |
| COUNTY <u>BALTO.</u>  |  | MARYLAND                       |  | STATE <u>Md.</u>   |  | COUNTY <u>PRINCE GEORGE</u> |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  |  | LENGTH OF STAY (In this place) |  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN                    |  |                             |  |
| <u>52 CATONSVILLE</u>   |  | <u>16 yrs.</u>                 |  | <u>BRADBURY</u>  |  | <u>Agts. 16x-2</u>          |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |  |                                |  | STREET ADDRESS (If rural give location)  |  |                             |  |
| <u>14 Spring Grove State Hosp.</u>  |  |                                |  |  |  |                             |  |
| 3. NAME OF DECEASED: (Type or Print)  |  |                                |  | 4. DATE OF DEATH:  |  |                             |  |
| (First) (Middle) (Last)   |  |                                |  | (Month) (Day) (Year)   |  |                             |  |
| <u>MARTHA ELIZABETH SIMMS</u>   |  |                                |  | <u>7-2-55</u>  |  |                             |  |
| 5. SEX  |  | 6. COLOR OR RACE               |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED.   |  | 8. DATE OF BIRTH:           |  |
| <u>F</u>  |  | <u>W</u>                       |  |  |  | <u>8-31-1884</u>            |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  |  |                                |  | 10B. KIND OF BUSINESS OR INDUSTRY:   |  |                             |  |
| <u>HOUSEWORK</u>  |  |                                |  | <u>MARYLAND</u>  |  |                             |  |
| 13. FATHER'S NAME:  |  |                                |  | 12. CITIZEN OF WHAT COUNTRY?   |  |                             |  |
|   |  |                                |  | <u>USA</u>   |  |                             |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |  |                                |  | 16. SOCIAL SECURITY NO   |  |                             |  |
|   |  |                                |  |  |  |                             |  |
| 17. INFORMANT & ADDRESS:  |  |                                |  | 18. MEDICAL CERTIFICATION  |  |                             |  |
| <u>HUSBAND</u>  |  |                                |  | INTERVAL BETWEEN ONSET AND DEATH   |  |                             |  |
| <u>CHARLES SIMMS - DECEASED</u>   |  |                                |  |  |  |                             |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |                                |  | 2. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. |  |                             |  |
| <u>162x</u>   |  |                                |  | <u>IMMEDIATE CAUSE</u>   |  |                             |  |
| <u>ANTECEDENT CAUSE (S):</u>  |  |                                |  | <u>(A) Atelectasis left lung</u>   |  |                             |  |
|   |  |                                |  | <u>DUE TO</u>  |  |                             |  |
|   |  |                                |  | <u>(B) Extreme left pleural effusion</u>   |  |                             |  |
|   |  |                                |  | <u>DUE TO</u>  |  |                             |  |
|   |  |                                |  | <u>(C) Bronchogenic carcinoma left lung</u>  |  |                             |  |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |                                |  | <u>Arterio-sclerotic cardiovascular disease</u>  |  |                             |  |
| 19A. DATE OF OPERATION:   |  |                                |  | 19B. MAJOR FINDINGS OF OPERATION   |  |                             |  |
| <u>0</u>  |  |                                |  |  |  |                             |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                           |  |                             |  |
|   |  |                                |  | 21C. WHERE DID (City or town) (County) (State)   |  |                             |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  |                                |  | 21E. INJURY OCCURRED While [ ] Not while [ ] at work [ ] at work [ ]                             |  |                             |  |
|   |  |                                |  | 21F. HOW DID INJURY OCCUR?   |  |                             |  |
|   |  |                                |  |  |  |                             |  |
| 22. I hereby certify that I attended the deceased from <u>1-14-1939</u> to <u>7-2-1955</u> that I last saw the deceased alive on <u>7-2-1955</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. |  |                                |  |  |  |                             |  |
| SIGNATURE   |  |                                |  | ADDRESS  |  |                             |  |
| <u>Harold Edwards MD - Spring Grove State Hosp.</u>   |  |                                |  | <u>DATE SIGNED 7-2-55</u>  |  |                             |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                                |  | DATE THEREOF   |  |                             |  |
| <u>BURIED</u>   |  |                                |  | <u>July 8, 1955</u>  |  |                             |  |
| NAME OF CEMETERY OR CREMATORY   |  |                                |  | LOCATION (City, town, or county) (State)   |  |                             |  |
| <u>WASHINGTON NATL.</u>   |  |                                |  | <u>SWITLAND, Md.</u>   |  |                             |  |
| DATE REC'D BY LOCAL REGISTRAR   |  |                                |  | REGISTRAR'S SIGNATURE  |  |                             |  |
| <u>July 7, 1955</u>   |  |                                |  | <u>B. W. Laumann</u>   |  |                             |  |
| 24. FUNERAL DIRECTOR  |  |                                |  | ADDRESS  |  |                             |  |
| <u>M. M. Chambers, Co</u>   |  |                                |  | <u>1400 Chapin St. N.W.</u>  |  |                             |  |





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6427

## CERTIFICATE OF DEATH 334 Reg. Dist. No. 38

06430

|   |                                |  |  |
|---|--------------------------------|--|--|
| 1. PLACE OF DEATH.  |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |
| COUNTY <u>Baltimore</u> MARYLAND  |                                | STATE <u>New York</u> COUNTY   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>53 TOWSON</u>  |                                | CITY (If outside corporate limits, write RURAL and give nearest town) <u>69X-3</u>                     |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Armacost Nursing Home</u><br><u>812 Register Ave.</u>  |                                | STREET ADDRESS (If rural give location) <u>100 Greenwich Ave, Goshen, N. Y. ✓</u>                      |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><u>George</u> <u>Simon</u>  |                                | 4. DATE (Month) (Day) (Year)<br>OF DEATH: <u>7</u> <u>16</u> <u>19 55</u>                              |  |
| 5. SEX: <u>Male</u>   | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>  | 8. DATE OF BIRTH: <u>JULY 16, 1913</u> |
| 9. AGE last birthday: <u>42</u> yrs.  |                                | 10. IF UNDER 1 YEAR: Months Days Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Clerk</u>  |                                | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Grocery</u>  |  |
| 11. BIRTHPLACE (State or foreign country): <u>MIDDLETOWN, N. Y.</u>   |                                | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME: <u>JOHN SIMON</u>  |                                | 14. MOTHER'S MAIDEN NAME: <u>SILMA ZEHIA</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>no</u>  |                                | 16. SOCIAL SECURITY NO. <u>none</u>  |  |
| 17. INFORMANT'S ADDRESS: <u>Dr. Edward Simon</u><br><u>Havre de Grace, Md.</u>  |                                |  |  |
| 18. MEDICAL CERTIFICATION   |                                |  | INTERVAL BETWEEN ONSET AND DEATH       |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                |  |  |
| IMMEDIATE CAUSE (A) <u>Cerebral vascular collapse due to</u>  |                                |  | <u>7 1/2 hrs.</u>                      |
| DUE TO  |                                |  |  |
| ANTECEDENT CAUSE (B) <u>hyperpyrexia</u>  |                                |  |  |
| DUE TO  |                                |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |                                |  |  |
| (C) <u>heat stroke</u>  |                                |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>  |                                |  |  |
| 19A. DATE OF OPERATION:   |                                | 19B. MAJOR FINDINGS OF OPERATION   |  |
|   |                                |  |  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)  |                                | 21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)                                 |  |
|   |                                | 21C. WHERE DID (City or town) (County) (State)   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                | 21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  |
|   |                                | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <u>7-22</u> , 1954, to <u>7-16</u> , 1955, that I last saw the deceased alive on <u>7-16</u> , 1955, and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above. |                                |  |  |
| SIGNATURE <u>Frank J. Gray</u>  |                                | DATE SIGNED <u>7/16/55</u>   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>   |                                | DATE THEREOF <u>7/16/55</u>  |  |
| NAME OF CEMETERY OR CREMATORY <u>St. John's Cem.</u>  |                                | LOCATION (City, town, or county) (State) <u>Goshen, N.Y.</u>   |  |
| DATE REC'D BY LOCAL REGISTRAR <u>7-22-55</u>  |                                | REGISTRAR'S SIGNATURE <u>Mark C. Gray</u>  |  |
| FUNERAL DIRECTOR <u>Edm. J. Dickner</u>   |                                | ADDRESS <u>100 Greenwich Ave, Goshen, N.Y.</u>   |  |

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUL 19

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

642 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Items 9, 13, 14 Filed 8-9-55 at

06431

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

|  |                           |  |                                  |  |  |  |  |
|--|---------------------------|--|----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH  |                           |  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |  |  |
| COUNTY <u>Baltimore</u>  |                           | MARYLAND   |                                  | STATE <u>Maryland</u> COUNTY <u>Prince George</u>  |  |  |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>521 Cambridge 28</u>   |                           | LENGTH OF STAY (in this place) <u>since Feb-11-1955</u>  |                                  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Wash DC</u> |  | <u>168-21</u>  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove Hospital</u>  |                           |  |                                  | STREET ADDRESS (If rural give location) <u>2515 Lyons St Wash DC</u>                         |  | <u>21</u>  |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |                           |  |                                  | 4. DATE (Month) (Day) (Year)   |  |  |  |
| <u>EVA LUCILLE SIMPSON</u>   |                           |  |                                  | <u>7 30 1955</u>   |  |  |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>(SepH)</u>  | 8. DATE OF BIRTH <u>4-7-1882</u> | 9. AGE last birthday: <u>74</u> yrs  |  | IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of life, even if retired): <u>housewife</u>  |                           | 10B. KIND OF BUSINESS OR INDUSTRY:   |                                  | 11. BIRTHPLACE (State or foreign country): <u>USA</u>  |  | 12. CITIZEN OF WHAT COUNTRY: <u>USA</u>  |  |
| 13. FATHER'S NAME: <u>Edward McLelland</u>   |                           |  |                                  | 14. MOTHER'S MAIDEN NAME: <u>?? Martin</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMY OR FORECAST (Yes, no, or unk.) (If Yes, give war or dates of service)   |                           |  |                                  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT & ADDRESS  |  |
| 18. MEDICAL CERTIFICATION  |                           |  |                                  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                           |  |                                  |  |  |  |  |
| IMMEDIATE CAUSE (A) <u>4x0.1 Acute coronary thrombosis</u>   |                           |  |                                  |  |  | <u>3-4 days</u>  |  |
| ANTECEDENT CAUSE (B) <u>Coronary arteriosclerosis</u>  |                           |  |                                  |  |  | <u>years</u>   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerosis</u>  |                           |  |                                  |  |  | <u>years</u>   |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                           |  |                                  |  |  |  |  |
| 19A. DATE OF OPERATION:  |                           | 19B. MAJOR FINDINGS OF OPERATION   |                                  |  |  |  |  |
|  |                           |  |                                  |  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                                  | 21C. WHERE DID (City or town) (County) (State)   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                           | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
|  |                           |  |                                  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>7:30</u> , 19 <u>55</u> , to <u>3:20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7-30</u> , 19 <u>55</u> , and that death occurred at <u>3:20</u> P.M. from the causes and on the date stated above. |                           |  |                                  |  |  |  |  |
| SIGNATURE <u>V. E. Harry</u>   |                           | ADDRESS <u>M D Spring Grove State Hosp</u>   |                                  | DATE SIGNED <u>7-31-55</u>   |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u>  |                           | DATE THEREOF <u>8/2/55</u>   |                                  | NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>                                    |  | LOCATION (City, town, or county) (State) <u>Princetown, Md.</u>                  |  |
| DATE REC'D BY LOCAL REGISTRAR <u>7-31-55</u>   |                           | REGISTRAR'S SIGNATURE <u>V. E. Harry</u>   |                                  | 24. FUNERAL DIRECTOR <u>RINALDI, F. H.</u>   |  | ADDRESS <u>Washington, DC</u>  |  |

Housewife

F

W

EVA

LUCILE

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4-5-1885

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Postmaster  
Spring Grove Hotel  
Coburnville & 21st Feb. 1937

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2212, 21st Feb. 1937

Prince George  
21

22 30 22

3901

730 22

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06432  
6429 CERTIFICATE OF DEATH Reg. Dist. No.

|  |                                |  |   |
|--|--------------------------------|--|---|
| 1. PLACE OF DEATH:   |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |   |
| COUNTY <u>BALTIMORE</u> MARYLAND   |                                | STATE <u>MARYLAND</u> COUNTY <u>ANN. AL.</u>   |   |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>OAK PARK</u>   |                                | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LIAITHICUM</u>              |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1942 BELL AVE.</u>  |                                | STREET ADDRESS (If rural give location) <u>WINTERBORN &amp; ELK RIDGE RD.</u>                                |   |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |                                | 4. DATE OF DEATH: (Month) (Day) (Year)   |   |
| <u>ELIZABETH SLATER</u>  |                                | <u>JULY 17 1955</u>  |   |
| 5. SEX: <u>FEMALE</u>  | 6. COLOR OR RACE: <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>   | 8. DATE OF BIRTH: <u>MARCH 14, 1870</u> |
| 9. AGE last birthday: <u>85</u> yrs.   |                                | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWORK</u> |   |
| 11. BIRTHPLACE (State or foreign country): <u>VIRGINIA</u>   |                                | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME: <u>UNKNOWN</u>  |                                | 14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)   |                                | 16. SOCIAL SECURITY NO. <u>NONE</u>  |   |
| 17. INFORMANT & ADDRESS: <u>FREDERICK SLATER.</u>  |                                | 18. MEDICAL CERTIFICATION  |   |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                | INTERVAL BETWEEN ONSET AND DEATH   |   |
| 450.0 IMMEDIATE CAUSE (A) DUE TO <u>arteriosclerosis</u>   |                                |  |   |
| ANTECEDENT CAUSE (B) DUE TO <u>a terminal Pulmonary</u>  |                                |  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Edema</u>   |                                |  |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                                |  |   |
| 19A. DATE OF OPERATION:  |                                | 19B. MAJOR FINDINGS OF OPERATION   |   |
|  |                                |  |   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                |  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                       |   |
| 21C. WHERE DID (City or town) (County) (State)   |                                | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |   |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |                                | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <u>6/2</u> , 19 <u>55</u> , to <u>7/17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/17</u> , 19 <u>55</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. |                                |  |   |
| SIGNATURE <u>John C. Freney</u> M.D.   |                                | DATE SIGNED <u>7/19/55</u>   |   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>   |                                | 24. FUNERAL DIRECTOR ADDRESS   |   |
| DATE THEREOF <u>7/21/55</u>  |                                | LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>  |   |
| NAME OF CEMETERY OR CREMATORY <u>FALMOUTH</u>  |                                |  |   |
| DATE REC'D BY LOCAL REGISTRAR <u>JUL 23 1955</u>   |                                | REGISTRAR'S SIGNATURE <u>W. H. Kueffer</u>   |   |

MARGIN RESERVED FOR BINDING VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. DEPARTMENT OF AGRICULTURE

Technical Bulletin  
No. 100

6430

CERTIFICATE OF DEATH

Reg. Dist. No.

06433

44

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |
| COUNTY <b>Baltimore</b>  | MARYLAND  | STATE <b>Maryland</b>  | COUNTY   |
| CITY (If outside corporate limits, write RURAL and give nearest town)  | LENGTH OF STAY (In this place)  | CITY (If outside corporate limits, write RURAL and give nearest town)                        |  |
| TOWN <b>Fort Howard</b>  | <b>86 Days</b>  | TOWN <b>Baltimore</b>  | <b>3 Vol 1-4</b>   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hospital</b>  |   | STREET ADDRESS (If rural give location)  | <b>1720 Ramsey Street</b>  |
| 3. NAME OF DECEASED (Type or Print)  | (First) <b>CLARENCE</b>   | (Middle) <b>O.</b>   | (Last) <b>SMITH</b>  |
| 5. SEX: <b>Male</b>  | 6. COLOR OR RACE: <b>White</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>                             | 8. DATE OF BIRTH <b>10/9/95</b>  |
|  |   |  | 9. AGE last birthday <b>59</b> yrs   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  | <b>Painter</b>  | 10B. KIND OF BUSINESS OR INDUSTRY: <b>Government</b>   | 11. BIRTHPLACE (State or foreign country): <b>Baltimore, Maryland</b>        |
| 13. FATHER'S NAME: <b>Lewis Smith</b>  |   | 14. MOTHER'S MAIDEN NAME: <b>Anne Forrester</b>  | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>                                 |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>Yes</b>   | <b>WJ I</b>   | 16. SOCIAL SECURITY NO <b>213-03-3840</b>  | 17. INFORMANT & ADDRESS: <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b> |
| 18. MEDICAL CERTIFICATION  |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |   |  |  |
| IMMEDIATE CAUSE (A) <b>163X CARCINOMA OF RIGHT LUNG</b>  |   | <b>2 YEARS</b>   |  |
| ANTECEDENT CAUSE (B) <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST</b>                                     |   |  |  |
| (C)  |   |  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |   |  |  |
| 19A. DATE OF OPERATION <b>6-7-55</b>   | 19B. MAJOR FINDINGS OF OPERATION <b>THORACOTMY</b>  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)           | 21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)   | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                 |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>VA M.</b>   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that <b>X</b> attended the deceased from <b>Apr. 22, 1955</b> , to <b>July 17, 1955</b> , from the causes and on the date stated above. |   |  |  |
| SIGNATURE <b>WILLIAM B. VANDEGRIFT, M.D.</b>   |   | ADDRESS <b>M. D. VAH, FORT HOWARD, MARYLAND</b>  |  |
| DATE SIGNED <b>7-18-55</b>   |   |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   | DATE THEREOF <b>7-21-55</b>   | NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>                                      | LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>          |
| DATE REC'D. BY LOCAL REGISTRAR   | REGISTRAR'S SIGNATURE   | 24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Blight, Inc. 6009 Harford Rd. Baltimore 14, Md.</b> |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





06434

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

6431

|  |                               |  |                                     |
|--|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH-<br>COUNTY <u>Baltimore</u> MARYLAND   |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Md.</u> COUNTY <u>Balto.</u>        |                                     |
| CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Fullerton</u>                          |                               | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u> |                                     |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3850 Schroeder Ave.</u>   |                               | STREET ADDRESS (If rural, give location) <u>3850 Schroeder Ave.</u>                    |                                     |
| 3. NAME OF DECEASED (Type or Print) <u>DAVID M. SMITH</u>  |                               | 4. DATE OF DEATH <u>July 28, 1955</u>  |                                     |
| 5. SEX <u>male</u>   | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>                        | 8. DATE OF BIRTH <u>May 6, 1882</u> |
| 9. AGE last birthday <u>73</u> yrs.  |                               | 10. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>    |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookster</u>        |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>                                 |                                     |
| 11. BIRTHPLACE (State or foreign country) <u>Montgomery Co., Md.</u>   |                               | 12. CITIZEN OF WHAT COUNTRY <u>USA</u>   |                                     |
| 13. FATHER'S NAME <u>Dennis Smith</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Susie -- ?</u>   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) |                               | 16. SOCIAL SECURITY NO. <u>  </u>  |                                     |
| 17. INFORMANT AND ADDRESS <u>Fullerton, Md.</u>  |                               | 18. MEDICAL CERTIFICATION  |                                     |

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a).....

Myocardial Infarction

Antecedent cause(s)

(b).....

Carcinomatosis

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c).....

Bronchogenic Carcinoma, Anaplastic

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Bronchiectasis

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

## 20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1954, to 28 July, 1955, that I last saw the deceasedalive on 27 July, 1955, and that death occurred at 3 pm m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

burial

DATE THEREOF

8/1/55

NAME OF CEMETERY OR CREMATORY

St. Michaels Luth. Cem.

LOCATION (City, town, or county)

Balto. Co., Md.

(State)

DATE RECEIVED BY LOCAL REG.

2-31-55

LOCAL HEALTH OFFICER'S SIGNATURE

W. M. Hammett

24. FUNERAL DIRECTOR

Lansdown Funeral Home

ADDRESS

7401 Belair Rd.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. K. Adams

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6435  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 3/

Reg. Dist.

No. 3/

|  |                         |   |                                 |  |                              |  |                             |
|--|-------------------------|---|---------------------------------|--|------------------------------|--|-----------------------------|
| 1. PLACE OF DEATH:   |                         |   |                                 | 2. USUAL RESIDENCE (HOME) OF DECEASED:                               |                              |  |                             |
| COUNTY Baltimore   |                         | MARYLAND  |                                 | STATE Md.  |                              | COUNTY Baltimore   |                             |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   |                         | LENGTH OF STAY (In this place)  |                                 | CITY (If outside corporate limits write RURAL and give nearest town) |                              |  |                             |
| X TOWN Randallstown  |                         |   |                                 | TOWN Baltimore X   |                              |  |                             |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Liberty Road   |                         |   |                                 | STREET ADDRESS (If rural, give location) 7631 Liberty Road           |                              |  |                             |
| 3. NAME OF DECEASED: (Type or Print)   |                         | (First) Charles   |                                 | (Middle) Wilmer  |                              | (Last) Snyder  |                             |
| 4. DATE OF DEATH   |                         | (Month) July  |                                 | (Day) 8  |                              | (Year) 19 55   |                             |
| 5. SEX: Male   | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married   | 8. DATE OF BIRTH: Oct. 30, 1904 | 9. AGE last birthday: 50 yrs.  | IF UNDER 1 YEAR: Months Days |  | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Engineer   |                         | 10b. KIND OF BUSINESS OR INDUSTRY: Snyder & Crandall  |                                 | 11. BIRTHPLACE (State or foreign country): Baltimore, Md.            |                              | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |                             |
| 13. FATHER'S NAME: Charles Snyder  |                         |   |                                 | 14. MOTHER'S MAIDEN NAME: Alice M. Cox                               |                              |  |                             |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No   |                         | 16. SOCIAL SECURITY No.: 215-01-7741  |                                 | 17. INFORMANT & ADDRESS: Ethel R. Snyder - 7631 Liberty Rd.          |                              |  |                             |
| 18. MEDICAL CERTIFICATION  |                         |   |                                 |  |                              | INTERVAL BETWEEN ONSET AND DEATH   |                             |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.   |                         |   |                                 |  |                              | 15 min.  |                             |
| Immediate cause (a)..... Shot through right temple (Suicide)   |                         |   |                                 |  |                              |  |                             |
| DUE TO   |                         |   |                                 |  |                              |  |                             |
| Antecedent cause(s) (b)..... Mental depression   |                         |   |                                 |  |                              | 2 weeks  |                             |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)   |                         |   |                                 |  |                              |  |                             |
| 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None  |                         |   |                                 |  |                              |  |                             |
| 19a. DATE OF OPERATION: None   |                         | 19b. MAJOR FINDING OF OPERATION: None   |                                 |  |                              | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                             |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                         | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) INJURY highway                                       |                                 | 21c. (City or town) (County) (State)                                 |                              | Randallstown Baltimore Md.   |                             |
| 21d. TIME (Month) (Day) (Year) OF INJURY July 8, 55 A:15 M.  |                         | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |                                 | 21f. HOW DID INJURY OCCUR? Shot through head (Self inflicted)        |                              |  |                             |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                         |   |                                 |  |                              |  |                             |
| SIGNATURE  |                         | DATE THEREOF  |                                 | NAME OF CEMETERY OR CREMATORY  |                              | LOCATION (City, town, or county) (State)   |                             |
| E. L. Caples   |                         | 7/11/1955   |                                 | Lorraine Mausoleum   |                              | Baltimore, Md.   |                             |
| 23. BURIAL, CREMATION, REMOVAL (Specify): Entombment   |                         | DATE REC'D BY LOCAL REG. 7-11-55  |                                 | REGISTRAR'S SIGNATURE  |                              | 24. FUNERAL DIRECTOR Ellsworth Armacost  |                             |
|  |                         |   |                                 |  |                              | ADDRESS Ellsworth Armacost - 4600 Liberty Hgts. Ave. 7                           |                             |

J. P. Nowaki

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

06436

6433

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 12 Film 3184 7-2-55 et.

|  |                              |   |                  |
|--|------------------------------|---|------------------|
| 1. PLACE OF DEATH:<br>COUNTY <u>Baltimore</u> MARYLAND   |                              | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>Md</u> COUNTY                                    |                  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>52 Catonsville</u>              |                              | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Baltimore</u> 3101 |                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>House in Pines</u>   |                              | STREET ADDRESS (If rural, give location)<br><u>3300 Strathmore Ave</u>                              |                  |
| 3. NAME OF DECEASED<br>(Type or Print) <u>IDA</u> (First) (Middle) (Last) <u>SNYDER</u>                          |                              | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>7</u> <u>21</u> <u>1955</u>                          |                  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)  | 8. DATE OF BIRTH |
| 9. AGE last birthday<br><u>70</u> yrs.   |                              | 10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House wife</u> |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |                  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Russia</u>   |                              | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                  |
| 13. FATHER'S NAME<br><u>Meyer Pass</u>   |                              | 14. MOTHER'S MAIDEN NAME<br><u>Sora</u>   |                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)         |                              | 16. SOCIAL SECURITY NO.   |                  |
| 17. INFORMANT AND ADDRESS<br><u>Milton Snyder - Same</u>   |                              |   |                  |

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Acute Congestive Heart Failure

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

Arteriosclerotic C.V.D. Disease  
Generalized ArteriosclerosisDecubital Ulceration - Septicemia

INTERVAL BETWEEN ONSET AND DEATH

4 da.?22nd

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION                           |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)          |  | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY                                 |  | (CITY OR TOWN) (COUNTY) (STATE)   |  |
| TIME (Month) (Day) (Year) (Hour) (Minute) INJURY |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from 12-24, 1954, to 7-21, 1955, that I last saw the deceased alive on 7-21, 1955, and that death occurred at 5:40 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

|   |  |                       |                               |  |
|---|--|-----------------------|-------------------------------|--|
| 23. BURIAL, CREMATION REMOVAL (Specify) |  | DATE THEREOF          | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| <u>Burial</u>                           |  | <u>7-22-55</u>        | <u>Abrew Young Men</u>        | <u>Baltimore Md</u>                      |
| DATE RECEIVED BY LOCAL REG.             |  | REGISTRAR'S SIGNATURE |                               | FUNERAL DIRECTOR ADDRESS                 |
| <u>7/22/55</u>                          |  | <u>Clara Hedrick</u>  |                               | <u>2100 Eastow Rd</u>                    |



PLEASE WRITE PLAINLY, WITH UNFADING INK.\* Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

06437

6757

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH-<br>COUNTY <b>BALTO</b> MARYLAND  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <b>MD</b> COUNTY <b>BALTO</b>  |   |
| CITY (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>  |  | CITY (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>   |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>IN CASEK IN REAR OF 7100 BLOCK FAIRGREEN RD.</b>   |  | STREET ADDRESS <b>DUNDALK 22, MD.</b>  |   |
| 3. NAME OF DECEASED (Type or Print)   | (First) <b>PAUL</b> (Middle) <b>MARION</b> (Last) <b>SPERANZELLA</b> | 4. DATE OF DEATH (Month) <b>July</b> (Day) <b>5</b> (Year) <b>1955</b>   |   |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W.</b>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>SINGLE</b>   | 8. DATE OF BIRTH <b>AUG. 15, 1939</b> 15 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country) <b>MD.</b>  |  | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>  |   |
| 13. FATHER'S NAME <b>GUS SPERANZELLA</b>  |  | 14. MOTHER'S MAIDEN NAME <b>HELEN FREMATTI</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <b>NONE</b>  |   |
| 17. INFORMANT <b>GUS SPERANZELLA</b>  |  |  |   |
| 18. MEDICAL CERTIFICATION   |  |  |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH<br><b>724.8</b><br>Immediate cause (a) <b>DROWNING</b><br>Antecedent cause(s) (b) _____<br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>_____     |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing in the death but not related to the disease or condition causing death.   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION   |   |
| 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |  | PLACE (Home, farm, factory, street, OF INJURY <b>Swimming</b> ) (CITY OR TOWN) <b>Dundalk</b> (COUNTY) <b>BALTO</b> (STATE) <b>MD.</b>                                     |   |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <b>7-4-55 11:30 pm.</b>  |  | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <b>WAS SWIMMING &amp; BANK-CASE NOT</b> |   |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> . |  |  |   |
| SIGNATURE <b>W. J. Davis M.D.</b>   |  | DATE SIGNED <b>7/5/55</b>  |   |
| 23. RITUAL CREMATION REMOVAL (Specify) <b>REMOVAL</b>   |  | DATE THEREOF <b>7-8-55</b>   |   |
| NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>  |  | LOCATION (City, town, or county) <b>BALTO, MD.</b> (State)   |   |
| DATE REC'D BY LOCAL REG. <b>July 5-1955</b>   |  | REGISTRAR'S SIGNATURE <b>William M Kelly</b>   |   |
| 24. FUNERAL DIRECTOR, ADDRESS <b>St. Luke's Cemetery, Dundalk, Md.</b>  |  |  |   |

U.S.



06438

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

## 1. PLACE OF DEATH:

COUNTY *Balto.*

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN *Sparrows Point.*

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

*End of Coal Pier waters of Patuxent River*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE *Md.*

COUNTY

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN *Baltimore.*

STREET ADDRESS (If rural, give location)

*875 N. Franklin St.*

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

*Leonard Cecil Spriggs*

4. DATE OF DEATH

(Month)

(Day)

(Year)

*July 20 1955*

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

*Male**Col.**Single**May-30-1920**35**35 yrs.*

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT &amp; ADDRESS:

*Yes**213-18-1292**Blanche Spriggs same*

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

*929.8*

Immediate cause

(a).....

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,

(b)....

giving rise to the above cause

DUE TO

stating underlying cause last

(c)

*Drowning (accidental).*

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

*Wm. Carmine M.D.*

M. D.

CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*7/21/55**W.K. Hedrick**Edw. O. Wilson**1000 Broadway*

VS. A15A - 5 - 53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



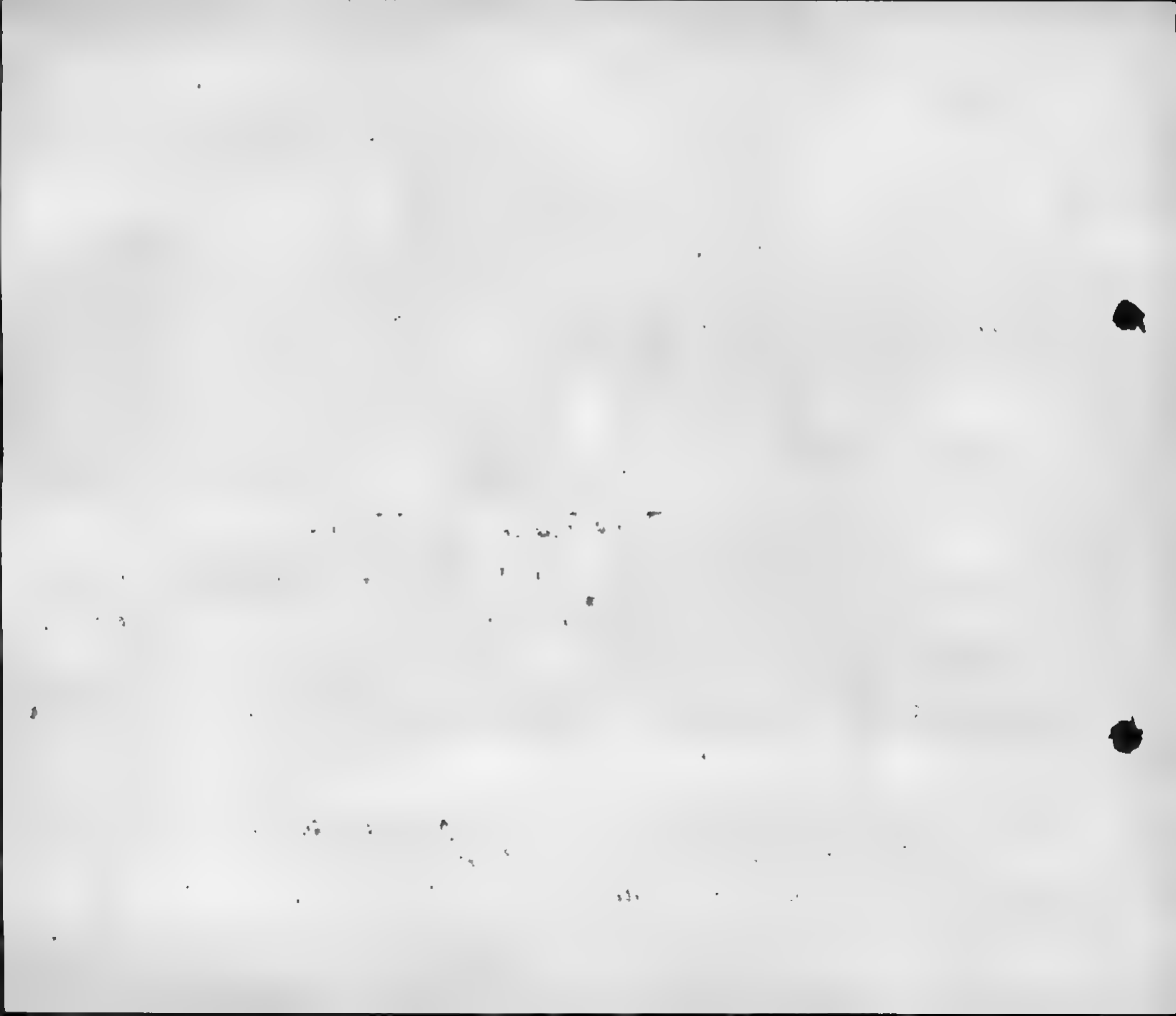
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06439  
6435  
CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                               |  |                                      |  |                 |  |  |
|--|-------------------------------|--|--------------------------------------|--|-----------------|--|--|
| 1. PLACE OF DEATH:   |                               |  |                                      | 2. USUAL RESIDENCE (HOME) OF DECEASED.   |                 |  |  |
| COUNTY <u>Balto.</u>   |                               | MARYLAND   |                                      | STATE <u>Md.</u>   |                 | COUNTY <u>Balto.</u>                     |  |
| CITY (If outside corporate limits, write RURAL or and give nearest town) <u>owson</u>  |                               | LENGTH OF STAY (in this place) <u>3 days</u>   |                                      | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>owson</u> |                 |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>215 Cold Home</u>   |                               |  |                                      | STREET ADDRESS (If rural give location) <u>200 Rogers Ford Rd.</u>                         |                 |  |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>Ludwig Adolph Staib</u>  |                               |  |                                      | 4. DATE (Month) (Day) (Year) OF DEATH <u>July 26 1955</u>                                  |                 |  |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>  | 8. DATE OF BIRTH: <u>Dec 26 1875</u> | 9. AGE last birthday <u>79</u> yrs.  | IF UNDER 1 YEAR | IF UNDER 24 HRS.                         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>  |                               | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Printer</u>  |                                      | 11. BIRTHPLACE (State or foreign country): <u>Balto Md</u>                                 |                 | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |  |
| 13. FATHER'S NAME: <u>Adolph Staib</u>   |                               |  |                                      | 14. MOTHER'S MAIDEN NAME: <u>Magaret Giger</u>   |                 |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>  |                               |  |                                      | 16. SOCIAL SECURITY NO. <u>No</u>  |                 |  |  |
| 17. INFORMANT & ADDRESS: <u>Mrs. Dorothy F. Staib</u>  |                               |  |                                      | <u>200 Rogers Ford Rd.</u>   |                 |  |  |
| 15. MEDICAL CERTIFICATION  |                               |  |                                      |  |                 | INTERVAL BETWEEN ONSET AND DEATH         |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                               |  |                                      |  |                 |  |  |
| IMMEDIATE CAUSE <u>334X</u>  |                               |  |                                      |  |                 |  |  |
| ANTECEDENT CAUSE (S):  |                               |  |                                      |  |                 |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |                               |  |                                      |  |                 |  |  |
| (A) <u>Paralysis Agitans</u>   |                               |  |                                      |  |                 | <u>5 yrs</u>                             |  |
| (B) <u>Arteriosclerosis, Cerebral &amp; general</u>  |                               |  |                                      |  |                 | <u>10 yrs</u>                            |  |
| (C) <u>Senility</u>  |                               |  |                                      |  |                 | <u>10 yrs</u>                            |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                               |  |                                      |  |                 |  |  |
| 19A. DATE OF OPERATION: <u>None</u>  |                               | 19B. MAJOR FINDINGS OF OPERATION   |                                      |  |                 |  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                      |  |                 |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH OR INJURY (If either, NOTIFY MEDICAL EXAMINER)   |                               | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>   |                                      | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)                               |                 |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                               | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                      | 21F. HOW DID INJURY OCCUR?   |                 |  |  |
| 22. I hereby certify that I attended the deceased from <u>July 24 1955</u> to <u>July 26 1955</u> , that I last saw the deceased alive on <u>July 24 1955</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above. |                               |  |                                      |  |                 |  |  |
| SIGNATURE <u>H.S. Chaffetz</u>   |                               | ADDRESS <u>M.D. 6210 York Rd.</u>  |                                      | DATE SIGNED <u>July 26 1955</u>  |                 |  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)   |                               | DATE THEREOF   |                                      | NAME OF CEMETERY OR CREMATORY  |                 | LOCATION (City, town, or county) (State) |  |
| <u>burial</u>  |                               | <u>July 29/55</u>  |                                      | <u>Louisa Park</u>   |                 | <u>Balto. Md.</u>                        |  |
| DATE REC'D BY LOCAL REGISTRAR  |                               | REGISTRAR'S SIGNATURE  |                                      | 24. FUNERAL DIRECTOR   |                 | ADDRESS                                  |  |
|  |                               |  |                                      | <u>Stewart Mowen Co.</u>   |                 | <u>Balto. Md.</u>                        |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6436

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

## 1. PLACE OF DEATH:

COUNTY Baltimore CountyCITY (If outside corporate limits, write RURAL LENGTH OF STAY  
OR and give nearest town) (in this place)55 TOWN Towson

5 mos. 11 das.

HOSPITAL OR INSTITUTION OR SHEPPARD &amp; ENOCH PRATT HOSP.,

13 STREET ADDRESS Towson 4, Maryland

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN BaltimoreSTREET ADDRESS 3706 N. CHARLES STREET,  
Buckingham Arms Apts., (18)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

EgilSteen

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

July221955

## 5. SEX:

6 COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS

MaleWhiteSingleApr. 8, 187778

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Lawyer & Grain MerchantNorwayU. S. A.

## 13. FATHER'S NAME:

Gerhard Steen

## 14. MOTHER'S MAIDEN NAME:

Madsella L. Madsen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT &amp; ADDRESS:

Hospital Records

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0  
Immediate cause

(a)

DUE TO

BRONCHO PNEUMONIAAntecedent causes (s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

GENERALIZED ARTERIO SCLEROSIS

(c)

Interval Between Onset And Death

UNKNOWN10 years

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☒ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11 Feb., 1955, to 22 July, 1955, that I last saw the deceased alive on 22 July, 1955, and that death occurred at 7:50 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

July 26, 1955Mark GrayJohn J. Lickner & Sons - Balto17 Mt.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

U.S. AIR FORCE

1955 2 10

100-100000

6253

06441

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 41

## I. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Dundalk 22 LENGTH OF STAY (in this place) 17 yrs  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 3000 DUNGLOW RD

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Ed. COUNTY Baltimore  
 CITY (If outside corporate limits write RURAL and give nearest town) Dundalk 53  
 STREET ADDRESS (If rural, give location) 2000 DUNGLOW ROAD

3. NAME OF DECEASED: (First) (Middle) (Last)  
 (Type or Print) WILLIAM H. STEIN

4. DATE OF DEATH (Month) (Day) (Year)  
July 11 1955

5. SEX: Male 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED 8. DATE OF BIRTH: 15 DEC. 1890 9. AGE last birthday: 64 yrs. 10. IF UNDER 1 YEAR: Months: Days: 11. IF UNDER 24 HRS. Hours: Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): HEATER 10b. KIND OF BUSINESS OR INDUSTRY: STEEL MFR. 11. BIRTHPLACE (State or foreign country): PENNA 12. CITIZEN OF WHAT COUNTRY? U.S.

## 13. FATHER'S NAME:

W. H. STEIN

## 14. MOTHER'S MAIDEN NAME:

MARY E. TRANSUE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 213-07-0046

## 17. INFORMANT &amp; ADDRESS:

CARLOS N. STEIN 2900 RITCHIE AVE  
ESSEX (19)

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

443X  
 Immediate cause (a) ... Arteriosclerotic cardiovascular disease.  
 DUE TO

Antecedent cause(s) (b) ...  
 Diseases or conditions, if any, giving rise to the above cause DUE TO  
 stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED White at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

William M. Kelly

M. D.

CHIEF MEDICAL EXAMINER ☐  
 DEPUTY MEDICAL EXAMINER ☐  
 ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED 7/11/55

23. BURIAL, CREMATION, REMOVAL (Specify):

BURIAL

DATE THEREOF

JULY 13, 1955

NAME OF CEMETERY OR CREMATORY

REFRESHING

LOCATION (City, town, or county)

HOWARD CO. Md.

(State)

DATE REC'D BY LOCAL REG.

July 12-1955

REGISTRAR'S SIGNATURE

William M. Kelly

FUNERAL DIRECTOR

Howard Co. Md.

ADDRESS

Howard Co. Md.

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6437

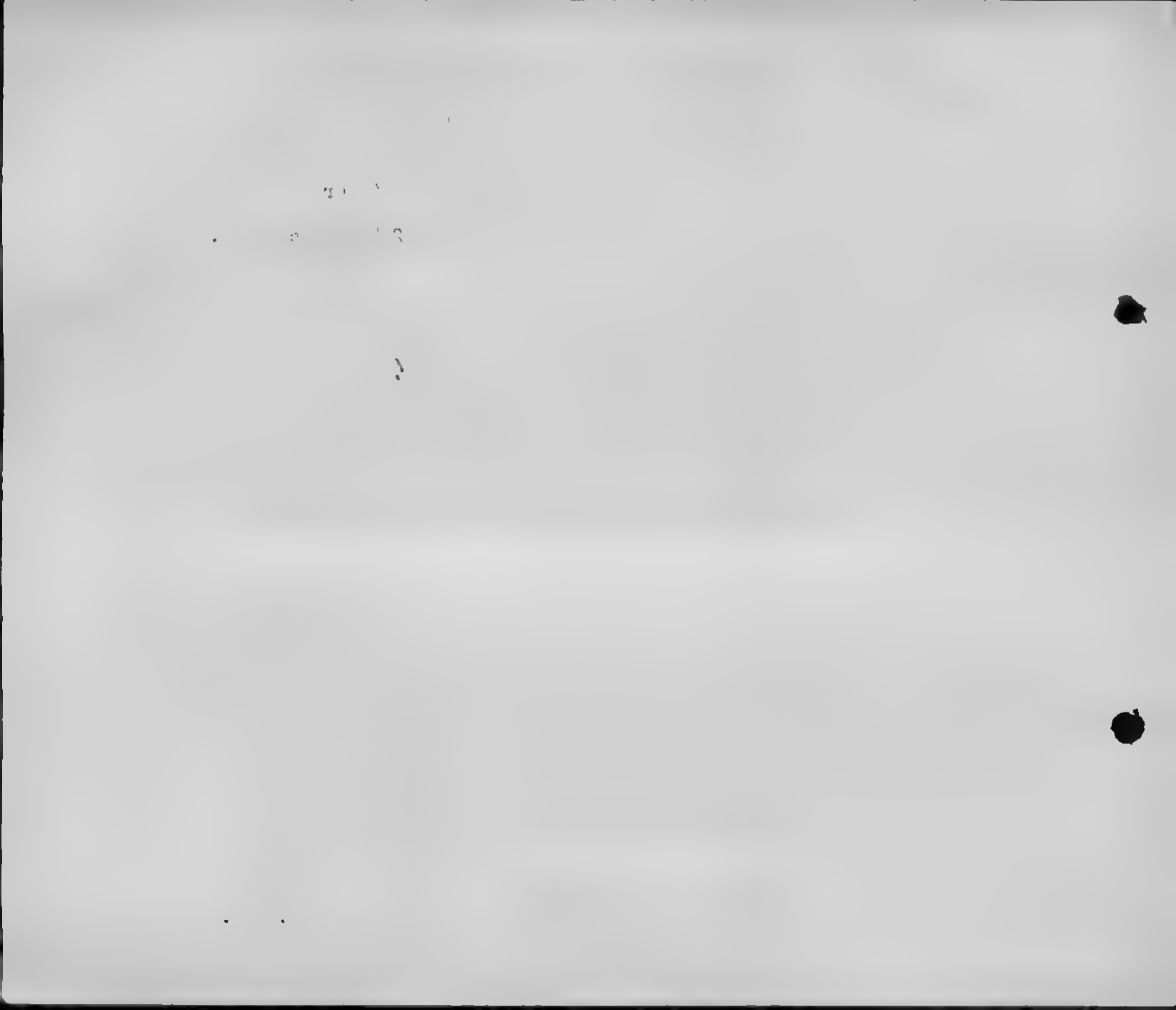
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06442

Reg. Dist.

No. 30

|   |                            |  |                                     |   |   |   |  |
|---|----------------------------|--|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH:  |                            |  |                                     | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |   |   |  |
| COUNTY <u>Baltimore</u>   |                            | MARYLAND   |                                     | STATE <u>Md</u>   |   | COUNTY <u>Balto</u>   |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br>TOWN <u>catonville</u>  |                            | LENGTH OF STAY (in this place)<br><u>20 yrs +</u>  |                                     | CITY (If outside corporate limits write RURAL and give nearest town)<br>OR TOWN <u>Baltimore</u> <u>34014</u> |   |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove St. Hosp.</u>   |                            |  |                                     | STREET ADDRESS (If rural, give location)<br><u>2204 Kentucky Ave.</u>   |   |   |  |
| 3. NAME OF DECEASED: (First) <u>Louise</u> (Middle) <u>STIEFEL</u> (Last) <u>STIEFEL</u>  |                            |  |                                     | 4. DATE OF DEATH (Month) <u>7</u> (Day) <u>10</u> (Year) <u>1955</u>  |   |   |  |
| 5. SEX: <u>F</u>  | 6. COLOR OR RACE: <u>N</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>  | 8. DATE OF BIRTH: <u>11/24/1865</u> | 9. AGE last birthday: <u>89</u> yrs.  | IF UNDER 1 YEAR: Months Days Hours Min. |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):   |                            | 10b. KIND OF BUSINESS OR INDUSTRY:   |                                     | 11. BIRTHPLACE (State or foreign country): <u>Illinois</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>✓</u>   |  |
| 13. FATHER'S NAME: <u>Herman Stiefel</u>  |                            |  |                                     | 14. MOTHER'S MAIDEN NAME: <u>Margaret Diefenbach</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)   |                            | 16. SOCIAL SECURITY No.: <u>no</u>   |                                     | 17. INFORMANT & ADDRESS: <u>Hospital records</u>  |   |   |  |
| 18. MEDICAL CERTIFICATION   |                            |  |                                     |   |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  |                            |  |                                     |   |   |   |  |
| <u>422.2</u><br>Immediate cause (a)..... <u>Acute Cardiac failure</u><br>DUE TO<br>Antecedent cause(s) (b)..... <u>Chronic Myocarditis</u><br>Diseases or conditions, if any, giving rise to the above cause DUE TO <u>Senility</u><br>stating underlying cause last (c).....   |                            |  |                                     |   |   |   |  |
| 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Mental illness</u>  |                            |  |                                     |   |   |   |  |
| 19a. DATE OF OPERATION: <u>11</u>   |                            | 19b. MAJOR FINDING OF OPERATION:   |                                     |   |   | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                        |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                            | 21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY)                                |                                     | 21c. (City or town) (County) (State)  |   |   |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                            | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                     | 21f. HOW DID INJURY OCCUR?  |   |   |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                            |  |                                     |   |   |   |  |
| SIGNATURE <u>Dr. McKieffer</u>  |                            | 1010 Stearns   |                                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>July 10, 53</u>                                |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>   |                            | DATE THEREOF <u>7/12/55</u>  |                                     | NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>  |   | LOCATION (City, town, or county) (State) <u>Balto., Md.</u>   |  |
| DATE REC'D BY LOCAL REG. <u>7-11-55</u>   |                            | REGISTRAR'S SIGNATURE <u>L</u>   |                                     | 24. FUNERAL DIRECTOR <u>Edm. J. Dieker &amp; Sons - Balto 1741d</u>   |   | ADDRESS   |  |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06443

6438

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH:   |  |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |  |  |  |
| COUNTY <b>Baltimore</b>  |  | MARYLAND  |  | STATE <b>Maryland</b>   |  | COUNTY <b>Washington</b>   |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   |  | LENGTH OF STAY (in this place)  |  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN |  |  |  |
| X TOWN <b>Owings Mills</b>   |  | <b>35 yrs.</b>  |  | TOWN <b>Hagerstown</b> <b>21-02</b>   |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Rosewood Training School</b>  |  |   |  | STREET ADDRESS (If rural, give location) <b>414 George Street,</b> ✓          |  |  |  |
| 3. NAME OF DECEASED: (First) <b>Ethel</b>  |  | (Middle) <b>Viola</b>   |  | (Last) <b>Straub</b>  |  | 4. DATE OF DEATH: (Month) <b>7</b> (Day) <b>20</b> (Year) <b>19 55</b>           |  |
| 5. SEX: <b>female</b>  |  | 6. COLOR OR RACE: <b>white</b>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <b>single</b>               |  | 8. DATE OF BIRTH: <b>5/27/08</b>   |  |
| 9. AGE last birthday: <b>47</b> yrs.   |  | 10. IF UNDER 1 YEAR: Months _____ Days _____  |  | 11. IF UNDER 24 HRS. Hours _____ Min. _____                                   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>--</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY: <b>--</b>                                  |  | 11. BIRTHPLACE (State or foreign country): <b>Maryland</b>                       |  |
| 12. CITIZENSHIP OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME: <b>George William Straub</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME: <b>Erma Fox</b>                                     |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>--</b>  |  |   |  | 16. SOCIAL SECURITY No.: <b>--</b>  |  | 17. INFORMANT & ADDRESS: <b>Rosewood Records</b>                                 |  |
| 18. MEDICAL CERTIFICATION  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |  |   |  |   |  |  |  |
| 421X Immediate cause (a) <b>Broncho-pneumonia, Bilateral</b>   |  |   |  |   |  | <b>2 days</b>  |  |
| Antecedent cause(s) (b) <b>DUE TO</b>  |  |   |  |   |  |  |  |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <b>DUE TO</b>   |  |   |  |   |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <b>Microcephaly</b>  |  |   |  |   |  | <b>Life</b>  |  |
| 19a. DATE OF OPERATION:  |  |   |  | 19b. MAJOR FINDINGS OF OPERATION:   |  | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| 21. ACCIDENT (Specify) <b>SUICIDE HOMICIDE</b>   |  | PLACE (Home, farm, factory, street, office bldg., etc.) <b>INJURY</b>                             |  | (CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____                             |  |  |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>7/18</b> , 19 <b>55</b> , to <b>7/20</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>7/20</b> , 19 <b>55</b> , and that death occurred at <b>1:05 p.m.</b> , from the causes and on the date stated above. |  |   |  |   |  |  |  |
| SIGNATURE <b>Larry H. Butler M.D.</b>  |  |   |  | (DEGREE OR TITLE) <b>Rosewood, Owings Mills Maryland</b>                      |  | DATE SIGNED <b>7/21/55</b>   |  |
| 23. BURIAL, CREMATION REMOVAL (Specify): <b>Burial</b>   |  | DATE THEREOF <b>7-22-55</b>   |  | NAME OF CEMETERY OR CREMATORY <b>West Haver Cemetery</b>                      |  | LOCATION (City, town, or county) (State) <b>Hagerstown Md</b>                    |  |
| DATE REC'D BY LOCAL REG <b>July 22 1955</b>  |  | REGISTRAR'S SIGNATURE <b>Larry B. Elmer</b>   |  | 24. FUNERAL DIRECTOR <b>West Haver Funeral Co.</b>                            |  | ADDRESS <b>Hagerstown, Md</b>  |  |

BUREAU A. 1

COPIES

1/15

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

6439

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH:   |  |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |   |  |
| COUNTY <i>Baltimore</i>  |  | MARYLAND  |  | STATE <i>Maryland</i>  |  | COUNTY <i>Balto.</i>  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)  |  | LENGTH OF STAY (in this place)  |  | CITY (If outside corporate limits, write RURAL and give nearest town)                  |  |   |  |
| OR TOWN <i>Jesse - Cockeysville P.O.</i>   |  | <i>4 yrs 5 mo 22 da</i>   |  | OR TOWN <i>Mohnton (Rural)</i>   |  | <i>X</i>  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Baltimore County Home</i>   |  |   |  | STREET ADDRESS <i>Jarretttsville Rd</i>  |  |   |  |
| 3. NAME OF DECEASED: (First) <i>Katherine</i> (Middle) <i>Henrietta</i> (Last) <i>Swank</i>  |  |   |  | 4. DATE OF DEATH: (Month) <i>July</i> (Day) <i>8</i> (Year) <i>1955</i>                |  |   |  |
| 5. SEX: <i>FEMALE</i>  |  | 6. COLOR OR RACE: <i>WHITE</i>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>WIDOWED</i>                       |  | 8. DATE OF BIRTH: <i>April 11, 1886</i>                                   |  |
| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>Housewife</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY: <i>Home</i>  |  | 9. AGE last birthday: <i>69</i> yrs. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. |  | 11. BIRTHPLACE (State or foreign country): <i>Baltimore Co., Maryland</i> |  |
| 13. FATHER'S NAME: <i>August Peter Richter</i>   |  |   |  | 14. MOTHER'S MAIDEN NAME: <i>Worthy Bloomer</i>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <i>no</i>  |  | 16. SOCIAL SECURITY No.: <i>none</i>  |  | 17. INFORMANT & ADDRESS: <i>Baltimore County Home Register Texas Md.</i>               |  |   |  |
| 18. MEDICAL CERTIFICATION  |  |   |  |  |  |   |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |   |  |  |  |   |  |
| 4521 Immediate cause   |  |   |  | (a) <i>Arterio-sclerotic cardio-vascular disease</i>                                   |  |   |  |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.  |  |   |  | (b) <i>disease</i>   |  |   |  |
|  |  |   |  | (c)  |  |   |  |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION:  |  |   |  | 19b. MAJOR FINDINGS OF OPERATION   |  |   |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  |  |   |  | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY                      |  | (CITY OR TOWN) (COUNTY) (STATE)   |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?  |  |   |  |
| 22. I hereby certify that I attended the deceased from <i>Jan. 1, 1951</i> , to <i>July 8, 1955</i> , that I last saw the deceased alive on <i>July 8, 1955</i> , and that death occurred at <i>11:50 A.M.</i> , from the causes and on the date stated above. |  |   |  |  |  |   |  |
| SIGNATURE (Degree or title) <i>Elizabeth B. Sherrill M.D.</i>  |  |   |  | ADDRESS <i>Cockeysville, Md.</i>   |  | DATE SIGNED <i>7/8/55</i>   |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)   |  | DATE THEREOF  |  | NAME OF CEMETERY OR CREMATORY  |  | LOCATION (City, town, or county) (State)                                  |  |
| <i>Burial</i>  |  | <i>7-11-55</i>  |  | <i>St. Johns Lutheran</i>  |  | <i>Phoenix, Md.</i>   |  |
| DATE REC'D BY LOCAL REGISTRAR  |  | REGISTRAR'S SIGNATURE   |  | 24. FUNERAL DIRECTOR   |  | ADDRESS   |  |
| <i>7/8/55</i>  |  | <i>Wm. J. L. Hiltz</i>  |  | <i>Beulah Funeral Service, Sparks, Md.</i>   |  | <i>J. Scott Brooks</i>  |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 12 1961

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## CERTIFICATE OF DEATH

Reg. Dist. No.

44

## 1. PLACE OF DEATH.

COUNTY

BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

LENGTH OF STAY  
(in this place)OR  
TOWN

FORT HOWARD

110 DAYS

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

VETERANS ADMINISTRATION HOSPITAL

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN BALTIMORE

STREET  
ADDRESS

(If rural give location)

5354 PATRICK HENRY DRIVE

3. NAME OF  
DECEASED:  
(Type or Print)

CURTIS

(First)

(Middle)

P.

(Last)

TATE

## 5 SEX

MALE

## 6 COLOR OR

WHITE

## 7 SINGLE, MARRIED,

WIDOWED, DIVORCED,  
(Specify): MARRIED

## 8 DATE OF BIRTH.

2-9-18

## 4. DATE (Month)

(Day)

(Year)

OF DEATH JULY

5

19 55

9. AGE last birthday; IF UNDER 1 YEAR IF UNDER 24 HRS.  
37 yrs Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life;  
even if retired)

MECHANIC

10B. KIND OF BUSINESS  
OR INDUSTRY:

AUTOMOBILE

## 11. BIRTHPLACE (State or foreign country).

MARION, NORTH CAROLINA

12. CITIZEN OF WHAT  
COUNTRY?

U. S. A.

## 13. FATHER'S NAME

JOSHUA C. TATE

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)

YES

(If Yes, give war or dates  
of service)

KOREAN

## 16. SOCIAL SECURITY NO.

245-01-0772

MARY LEE HOLLYFIELD

## 17. INFORMANT'S ADDRESS:

CLIN. REC., VET. ADM. HOSPITAL, FT. HOWARD, MD.

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

193X

IMMEDIATE CAUSE

(A)

OLIGODENDROGLIOMA

DUE TO

ANTECEDENT CAUSE (S):

(B)

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.INTERVAL BETWEEN  
ONSET AND DEATH

5 YEARS

## 19A. DATE OF OPERATION

4-1-55

## 19B. MAJOR FINDINGS OF OPERATION

Right craniotomy for brain tumor

## 20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

M.

21E. INJURY OCCURRED  
While ☐ Not while ☐  
at work ☐ at work ☐

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAR. 17, 1955, to JULY 5, 1955, and that death occurred at 10:05 PM from the causes and on the date stated above.

SIGNATURE

WILLIAM B. VANDEGRIFT

ADDRESS

DATE SIGNED

M. D. VAH, FORT HOWARD, MARYLAND 7-6-55

## 23. BURIAL, CREMATION, DATE THEREOF

REMOVAL (SPECIFY)

7-7-55

## NAME OF CEMETERY OR CREMATORY

OLD CEMETERY

## LOCATION (City, town, or county)

ALBEMARLE, N. CAROLINA

(State)

DATE RECEIVED BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

TO: LUTLEY FUNERAL HOME, ALBEMARLE, N. CAROLINA 609 HARTFORD ROAD, BALTIMORE 11, MD.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SHIPPED

3



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

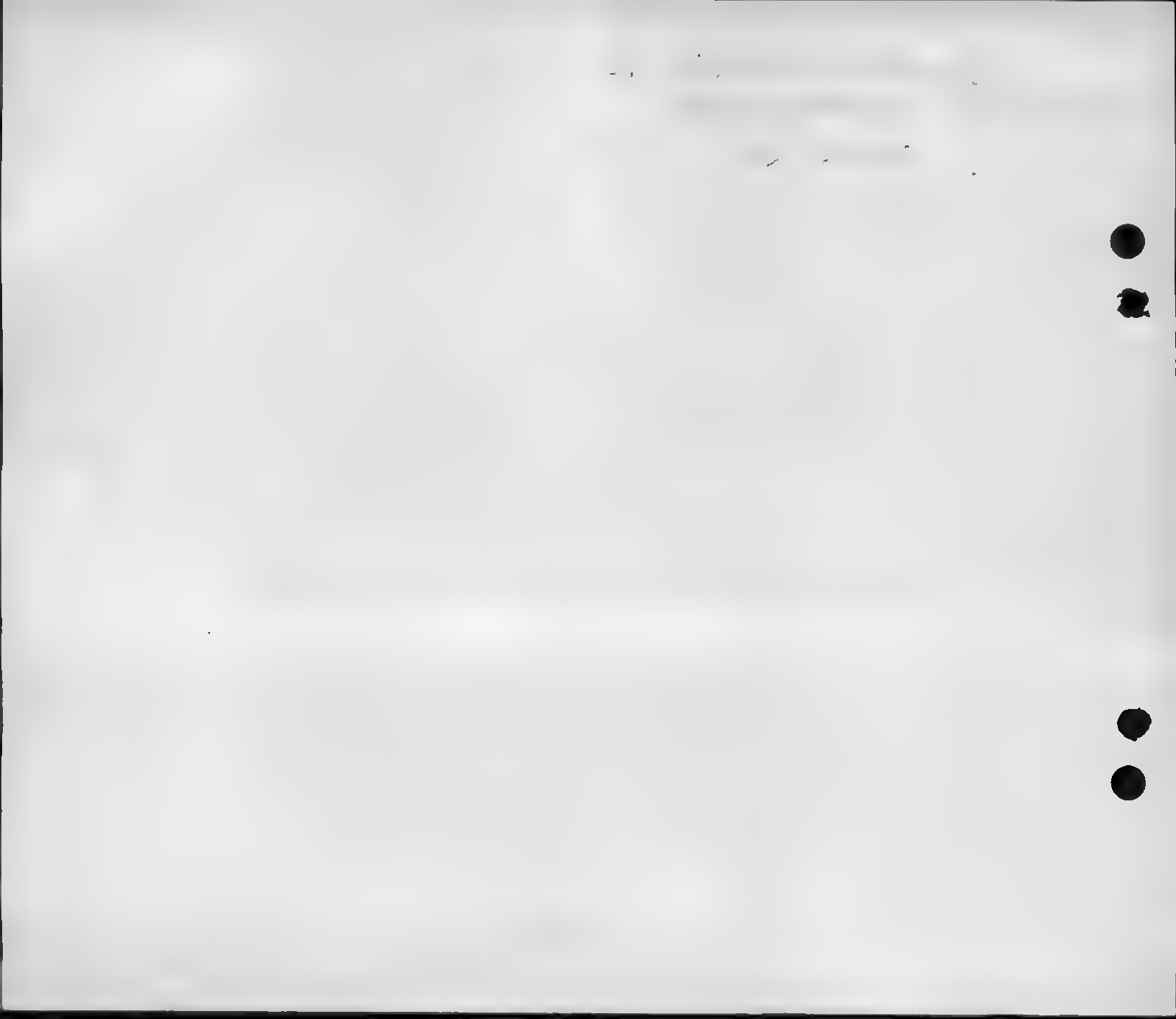
6441

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>COUNTY <b>Baltimore</b>  |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <b>Md.</b> COUNTY <b>Frederick</b>                 |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <b>Catonsville</b>  |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <b>Frederick</b>    |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Catonsville Convalescent Home</b>  |                                  | STREET ADDRESS (If rural, give location)<br><b>239 Washington St.</b>                             |  |
| 3. NAME OF DECEASED<br>(Type or Print)  | (First) <b>Mary</b>              | (Middle) <b>V.</b>  | (Last) <b>Thompson</b>   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>                                   | 4. DATE OF DEATH<br>(Month) <b>July</b> (Day) <b>21</b> (Year) <b>55</b> |
| 8. DATE OF BIRTH<br><b>Sept. 17, 1875</b>   |                                  | 9. AGE last birthday <b>79</b> yrs. If under 1 year Months Days Hours Min.                        |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>F. William Kuffmaul</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>M. Carrie Young</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY No.   |  |
| 17. INFORMANT AND ADDRESS<br><b>Charles Thompson</b>  |                                  | <b>Frederick, Md.</b>   |  |
| 18. MEDICAL CERTIFICATION   |                                  |   |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| 45 Immediate cause (a) <b>Myocardial infarct</b>  |                                  |   | <b>72 hrs</b>  |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last  |                                  |   |  |
| (c) <b>Arteriosclerotic CV disease</b>  |                                  |   | <b>1 yr</b>  |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Myocardial infarct</b>   |                                  |   |  |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |                                  |   |  |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)   |                                  | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY                                 | (CITY OR TOWN) (COUNTY) (STATE)  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  |
| HOW DID INJURY OCCUR?   |                                  |   |  |
| 22. I hereby certify that I attended the deceased from <b>May 24, 1955</b> , to <b>May 21, 1955</b> , that I last saw the deceased alive on <b>May 6, 1955</b> and that death occurred at <b>12:45 p.m.</b> , from the causes and on the date stated above. |                                  |   |  |
| SIGNATURE: <b>[Signature]</b>   |                                  | ADDRESS: <b>[Address]</b>   |  |
| DATE SIGNED: <b>May 24, 1955</b>  |                                  |   |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)  | DATE THEREOF                     | NAME OF CEMETERY OR CREMATORY   | LOCATION (City, town, or county) (State)                                 |
| <b>Burial</b>   | <b>7-24-1955</b>                 | <b>Mt. Olivet</b>   | <b>Frederick, Md.</b>  |
| DATE REC'D BY LOCAL REG. <b>7-22-55</b>   |                                  | 24. FUNERAL DIRECTOR<br><b>M.R. Etchison &amp; Son Frederick, Md.</b>                             |  |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06447

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## CERTIFICATE OF DEATH

Reg. Dist. No. 32

|   |                                |  |   |
|---|--------------------------------|--|---|
| 1. PLACE OF DEATH.  |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED.   |   |
| COUNTY <u>Baltimore</u>   | MARYLAND                       | STATE <u>Maryland</u> COUNTY <u>Baltimore</u>                                  |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)   | LENGTH OF STAY (In this place) | CITY (If outside corporate limits, write RURAL and give nearest town)          |   |
| X TOWN <u>Rural Stevenson</u>   |                                | OR TOWN <u>Rural Stevenson</u>   | X   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hillside Rd</u>  |                                | STREET ADDRESS (If rural give location) <u>Hillside Rd.</u>                    |   |
| 3. NAME OF DECEASED: (First) <u>Mrs. Nora</u> (Middle) <u>H.</u> (Last) <u>Topper</u>   |                                | 4. DATE (Month) (Day) (Year) OF DEATH: <u>July 2 1955</u>                      |   |
| 5. SEX. <u>Female</u>   | 6. COLOR OR RACE. <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married March 6, 1931</u> | 8. DATE OF BIRTH: <u>74 yrs.</u>                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>   |                                | 10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>                                 | 11. BIRTHPLACE (State or foreign country): <u>Ireland</u> |
| 13. FATHER'S NAME: <u>Martin Holmes</u>   |                                | 14. MOTHER'S MAIDEN NAME: <u>Miss Hopkins</u>                                  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>  |                                | 17. INFORMANT & ADDRESS: <u>John F. Topper Stevenson, Md.</u>                  |   |
| 18. MEDICAL CERTIFICATION   |                                |  | INTERVAL BETWEEN ONSET AND DEATH                          |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                |  |   |
| IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>   |                                |  | <u>2 1/2 yrs</u>  |
| ANTECEDENT CAUSE (B) <u>Hypertensive cardiovascular disease</u>   |                                |  | <u>8 yrs.</u>   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)   |                                |  |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                |  |   |
| 19A. DATE OF OPERATION: <u>1</u>  |                                | 19B. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)         |   |
| 21C. WHERE DID (City or town) (County) (State)  |                                | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                |   |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                                | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <u>4 Aug., 1948</u> , to <u>2 July</u> , 1955; that I last saw the deceased alive on <u>2 July</u> , 1955, and that death occurred at <u>6:50 P.</u> M., from the causes and on the date stated above. |                                |  |   |
| SIGNATURE <u>Paul H. Royce</u>  |                                | DATE SIGNED <u>2 July 55</u>   |   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |                                | NAME OF CEMETERY OR CREMATORY <u>New Catholic Cemetery</u>                     |   |
| DATE REC'D BY LOCAL REGISTRAR <u>JULY 4, 1955</u>   |                                | REGISTRAR'S SIGNATURE <u>Martha A. Russell</u>                                 |   |
| 24. FUNERAL DIRECTOR <u>Frank H. Russell</u>  |                                | ADDRESS <u>Baltimore</u>   |   |

WILLIAM A. J.

JUL 11 1955

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH:  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |   |
| COUNTY <u>Baltimore</u>   | MARYLAND                                      | STATE <u>Md</u>  | COUNTY <u>Baltimore</u>                   |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52200 Catonsville.</u>  | LENGTH OF STAY (in this place) <u>12 days</u> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkton</u> | X   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Hood Convalescent Home</u>  |   | STREET ADDRESS (If rural give location)  | <u>1</u>                                  |
| 3. NAME OF DECEASED:  |   | 4. DATE (Month) (Day) (Year)   |   |
| (First) <u>Mamie</u>  | (Middle) <u>A.</u>                            | (Last) <u>Trout</u>  | OF DEATH: <u>July 10, 1955</u>            |
| 5. SEX: <u>Female</u>   | 6. COLOR OR RACE: <u>White</u>                | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>                                | 8. DATE OF BIRTH: <u>January 26, 1875</u> |
| 9. AGE last birthday <u>80</u> yrs.   |   | 10. BIRTHPLACE (State or foreign country): <u>Stewartstown, Pa.</u>                          |   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |   |
| 13. FATHER'S NAME: <u>Joseph S. Hersey</u>  |   | 14. MOTHER'S MAIDEN NAME: <u>Susie Reynolds</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO   |   |
| 17. INFORMANT & ADDRESS: <u>C. R. Trout, New Freedom, Pa.</u>   |   |  |   |
| 18. MEDICAL CERTIFICATION   |   |  |   |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| IMMEDIATE CAUSE (A) <u>Myocarditis with Sudden Cardiac Failure</u>  |   | <u>1 day</u>   |   |
| ANTECEDENT CAUSE (B) <u>Arteriosclerotic C. V. Disease</u>  |   | <u>10 years</u>  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Wetral Insufficiency - Cardiac Hypertrophy</u>   |   |  |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |   |  |   |
| 19A. DATE OF OPERATION:   |   | 19B. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                       |   |
| 21C. WHERE DID (City or town) (County) (State)  |   | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |   |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <u>May 25, 1955</u> to <u>July 10, 1955</u> , that I last saw the deceased alive on <u>July 10, 1955</u> , and that death occurred at <u>10:45 P. M.</u> from the causes and on the date stated above. |   |  |   |
| SIGNATURE <u>John T. Coalahan</u>   |   | ADDRESS <u>4201 Wilkes Ln</u>  |   |
| DATE SIGNED <u>7/11/55</u>  |   |  |   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |   | DATE THEREOF <u>July 13, 1955</u>  |   |
| NAME OF CEMETERY OR CREMATORY <u>West Liberty Cemetery</u>  |   | LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>                              |   |
| DATE REC'D BY LOCAL REGISTRAR <u>7-12-55</u>  |   | REGISTRAR'S SIGNATURE <u>Victor C. Harry</u>   |   |
| FUNERAL DIRECTOR <u>W. Jacob Vorhies</u>  |   | ADDRESS <u>New Freedom, Pa.</u>  |   |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06449

6444

## CERTIFICATE OF DEATH

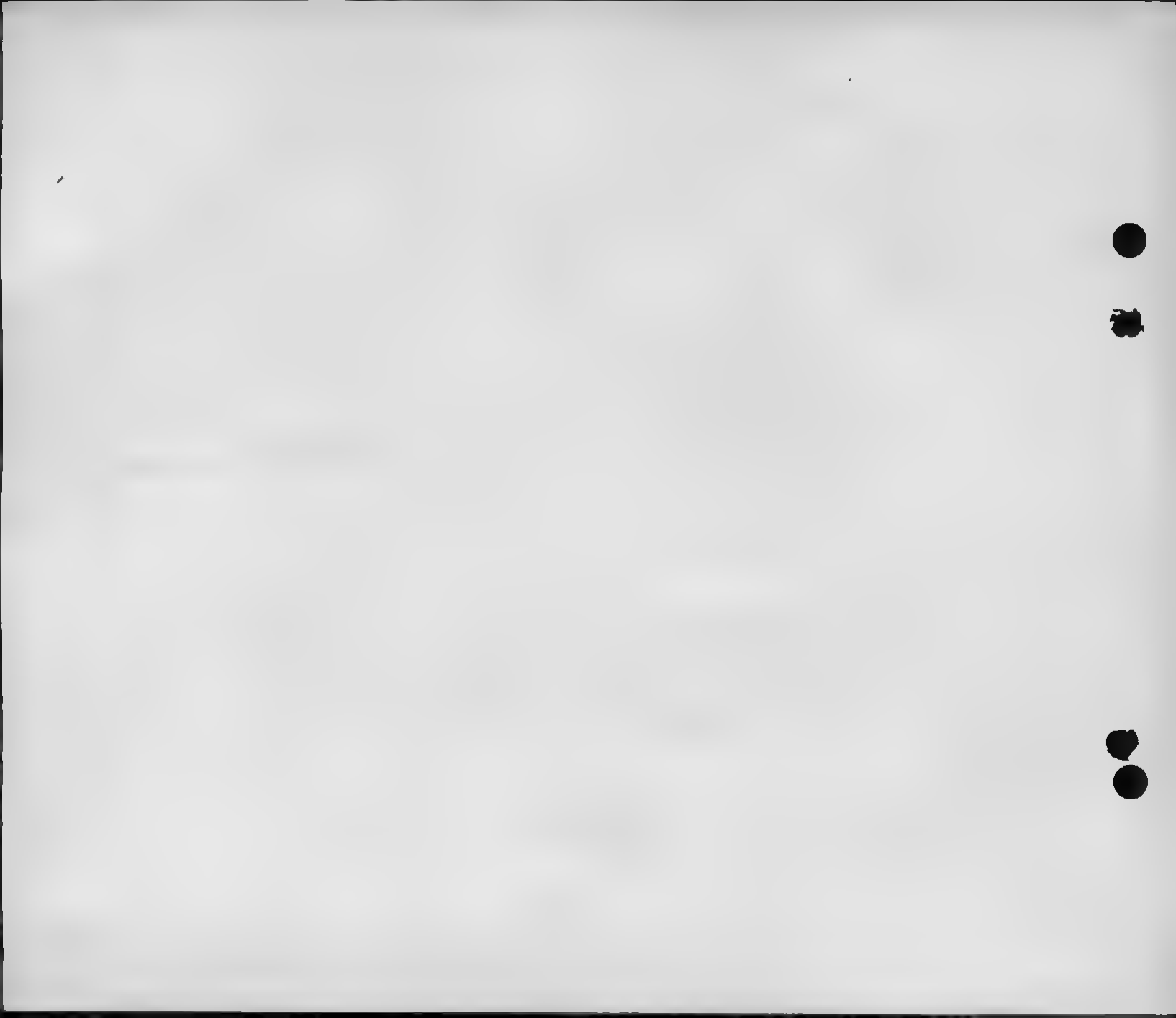
Reg. Dist. No. 31

|  |                                    |  |  |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH<br>COUNTY <u>Balto</u> MARYLAND  |                                    | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>2315 Water</u> COUNTY <u>Sto</u>                      |  |
| CITY (If outside corporate limits, write RURAL and, OR give nearest town) <u>None</u>  |                                    | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>                  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>  |                                    | STREET ADDRESS (If rural, give location) <u>1</u>  |  |
| 3. NAME OF DECEASED<br>(Type or Print) <u>Delzora Lures Troy</u>   |                                    | 4. DATE OF DEATH<br>(Month) <u>July</u> (Day) <u>28</u> (Year) <u>1965</u>                               |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>Colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH<br><u>7-3</u> yrs.                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country)<br><u>Ind.</u> |
| 12. CITIZEN OF WHAT COUNTRY?   |                                    | 13. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |  |
| 14. FATHER'S NAME<br><u>Gabriel Pollock</u>  |                                    | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) |  |
| 16. SOCIAL SECURITY No.  |                                    | 17. INFORMANT'S NAME AND ADDRESS<br><u>Sylvester Pollock</u>   |  |
| 18. MEDICAL CERTIFICATION  |                                    |  |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                    |  | INTERVAL BETWEEN ONSET AND DEATH                         |
| 4-14 Immediate cause (a) <u>Chronic 7. cervical tumor</u>  |                                    |  | <u>2 Year</u>  |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last   |                                    |  |  |
| (c)  |                                    |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension</u>  |                                    |  |  |
| 19a. DATE OF OPERATION   |                                    | 19b. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |                                    |  |  |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE  |                                    | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY  | (CITY OR TOWN) (COUNTY) (STATE)                          |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                    | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>        |  |
|  |                                    | HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <u>June 17, 1965</u> , to <u>July 28, 1965</u> , that I last saw the deceased alive on <u>July 27, 1965</u> , and that death occurred at <u>10:4</u> m. from the causes and on the date stated above. |                                    |  |  |
| SIGNATURE <u>[Signature]</u>   |                                    | ADDRESS <u>[Address]</u>   |  |
| DATE SIGNED <u>7-28-65</u>   |                                    |  |  |
| 23. BURIAL, CREMATION REMOVAL (Specify)  |                                    | DATE THEREOF   |  |
| NAME OF CEMETERY OR CREMATORY  |                                    | LOCATION (City, town, or county) (State)   |  |
| DATE REC'D BY LOCAL REG.   |                                    | 24. FUNERAL DIRECTOR   |  |
| REGISTRAR'S SIGNATURE <u>[Signature]</u>   |                                    | ADDRESS <u>Sears &amp; Henry</u>   |  |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06450

6445

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

|   |                                |  |                                       |
|---|--------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH:  |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                                       |
| COUNTY <u>Baltimore</u>   | MARYLAND                       | STATE <u>Maryland</u>  | COUNTY <u>Baltimore</u>               |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>X</u> TOWN <u>Libertyville</u>  | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Libertyville</u> | <u>X</u>                              |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2314 Towson Avenue</u>   |                                | STREET ADDRESS (If rural give location) <u>2314 Towson Avenue</u>                                    |                                       |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><u>NORMAN J WAGNER</u>  |                                | 4. DATE (Month) (Day) (Year)<br>OF DEATH: <u>July 6, 1955</u>  |                                       |
| 5. SEX: <u>Male</u>   | 6. COLOR OR RACE: <u>W</u>     | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>                                     | 8. DATE OF BIRTH: <u>Oct. 3, 1903</u> |
| 9. AGE last birthday: <u>56</u> yrs.  |                                | 10. UNDER 1 YEAR: Months Days  | 11. UNDER 24 HRS: Hours Min.          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>   |                                | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Gen. Construction</u>  |                                       |
| 11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>  |                                | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                                       |
| 13. FATHER'S NAME: <u>Benjamin C. Wagner</u>  |                                | 14. MOTHER'S MAIDEN NAME: <u>Kate Wagner</u>   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>   |                                | 16. SOCIAL SECURITY NO. <u>21-32-260</u>   |                                       |
| 17. INFORMANT & ADDRESS: <u>Family Doctor</u>   |                                |  |                                       |
| 18. MEDICAL CERTIFICATION   |                                |  | INTERVAL BETWEEN ONSET AND DEATH      |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                |  |                                       |
| IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>  |                                |  | <u>10 days</u>                        |
| ANTECEDENT CAUSE (B) <u>Hypertensive Carditis</u>   |                                |  |                                       |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Renal Vascular Disease</u>   |                                |  | <u>10 yrs</u>                         |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                |  |                                       |
| 19A. DATE OF OPERATION:   |                                | 19B. MAJOR FINDINGS OF OPERATION   |                                       |
|   |                                |  |                                       |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                |  |                                       |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                | 21B. PLACE (Home, farm, factory, street, office bldg., etc.)   |                                       |
| 21C. WHERE DID (City or town) (County) (State)  |                                | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                       |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                                | 21F. HOW DID INJURY OCCUR?   |                                       |
| 22. I hereby certify that I attended the deceased from <u>Jan 1948</u> to <u>July 6, 1955</u> , that I last saw the deceased alive on <u>July 6, 1955</u> , and that death occurred at <u>7:00 P</u> M, from the causes and on the date stated above. |                                |  |                                       |
| SIGNATURE <u>Charles F. Dornell</u>   |                                | DATE SIGNED <u>7/6/55</u>  |                                       |
| ADDRESS <u>7501 York Rd</u>   |                                | M. D. <u>Towson, Md.</u>   |                                       |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |                                | DATE THEREOF <u>July 9, 1955</u>   |                                       |
| NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>   |                                | LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>                                     |                                       |
| DATE REC'D BY LOCAL REGISTRAR <u>11/2/55</u>  |                                | REGISTRAR'S SIGNATURE <u>Rene Wmstead</u>  |                                       |
| FUNERAL DIRECTOR <u>Burns Sons</u>  |                                | ADDRESS <u>Towson, Md.</u>   |                                       |

7-2 111111

10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6445  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 45

06452  
Reg. Dist.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH:   |  |   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |  |  |  |
| COUNTY <u>Baltimore</u>  |  | MARYLAND  |  | STATE <u>Texas</u>  |  | COUNTY   |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br><u>Middle River</u>  |  |   |  | CITY (If outside corporate limits write RURAL and give nearest town)<br><u>Ham Anillo</u>   |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>Green L. Martin Co. Runway Middle River Md.</u>  |  |   |  | STREET ADDRESS (If rural, give location)<br><u>1414 1/2 N. N. St.</u>   |  |  |  |
| 3. NAME OF DECEASED:   |  |   |  | 4. DATE OF DEATH  |  |  |  |
| (First) <u>Roy</u>   |  | (Middle) <u>Chandler</u>  |  | (Last) <u>Wagster</u>   |  | (Month) (Day) (Year)<br><u>June 12 1955</u>              |  |
| 5. SEX: <u>M</u>   |  | 6. COLOR OR RACE: <u>White</u>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>  |  | 8. DATE OF BIRTH: <u>Dec 7, 1922</u>                     |  |
| 9. AGE last birthday: <u>32</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of work life, even retired): <u>U.S. Air Force</u>       |  | 11. BIRTHPLACE (State or foreign country): <u>Mobile Alabama</u>  |  | 12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>                 |  |
| 13. FATHER'S NAME: <u>Roy C Wagster Sr.</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME: <u>Unknown</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY No.:  |  | 17. INFORMANT & ADDRESS:                                 |  |
| 18. MEDICAL CERTIFICATION  |  |   |  |   |  |  |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH                         |  |
| Immediate cause (a) <u>3rd + 4th degree burns of entire body</u><br>DUE TO   |  |   |  |   |  |  |  |
| Antecedent cause(s) (b) <u>None</u><br>Diseases or conditions, if any, giving rise to the above cause DUE TO   |  |   |  |   |  |  |  |
| stating underlying cause last (c)  |  |   |  |   |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION: <u>None</u>  |  |   |  | 19b. MAJOR FINDING OF OPERATION: <u>None</u>  |  |  |  |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |   |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Middle River - ALA</u>                 |  | 21c. (City or town) (County) (State)<br><u>Middle River - ALA</u>   |  |  |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>7-12-55 1:15 P.M.</u>  |  | 21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR? <u>Struck in Air by tail fin (120 mph)</u>   |  |  |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |  |   |  |  |  |
| SIGNATURE: <u>Roy C. Wagster Jr.</u>   |  |   |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7/14/55</u><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>   |  | DATE THEREOF: <u>7-15-55</u>  |  | NAME OF CEMETERY OR CREMATORY: <u>Mobile</u>  |  | LOCATION (City, town, or county) (State): <u>Alabama</u> |  |
| DATE REC'D BY LOCAL REG. <u>7-15-55</u>  |  | REGISTRAR'S SIGNATURE: <u>[Signature]</u>   |  | FUNERAL DIRECTOR: <u>Book Luc. 1212 St Paul St</u>  |  | ADDRESS: <u>[Address]</u>                                |  |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6447

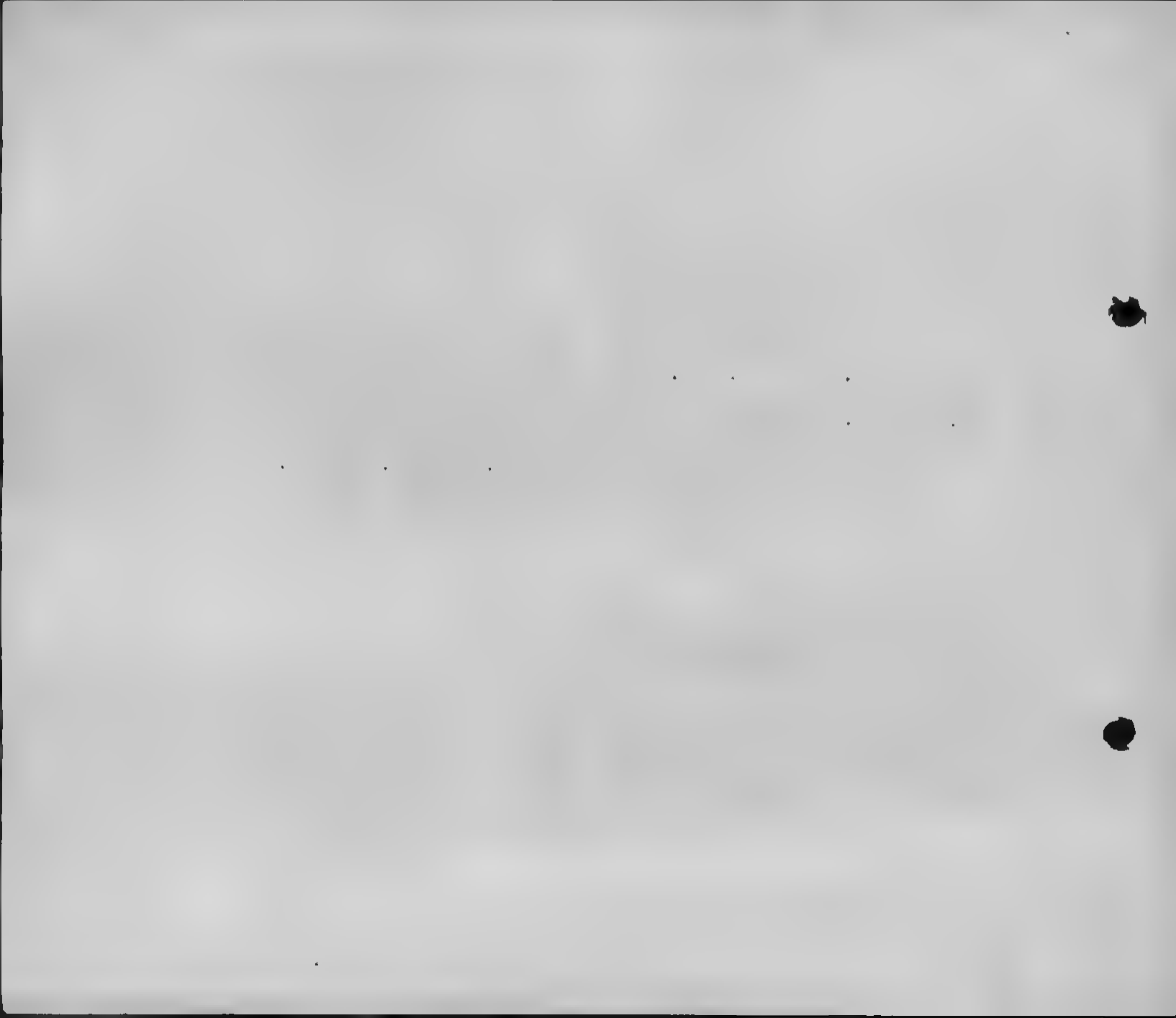
06453

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

|  |                                |  |   |
|--|--------------------------------|--|---|
| 1. PLACE OF DEATH:<br>COUNTY <u>COUNTY BALTIMORE</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>None</u><br>TOWN <u>NE SPARROWS PT - 19</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>(M. L. L. S. Island)</u>   |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>Maryland</u> COUNTY <u>None</u><br>CITY (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u><br>TOWN <u>None</u><br>STREET ADDRESS (If rural, give location) <u>4815 Richard Avenue #14</u> |   |
| 3. NAME OF DECEASED:<br>(Type or Print) <u>Ronald</u> (First) <u>Lawson</u> (Middle) <u>Wallace</u> (Last)   |                                | 4. DATE OF DEATH <u>JULY 3</u> 19 <u>55</u><br>(Month) (Day) (Year)  |   |
| 5. SEX: <u>male</u>  | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>  | 8. DATE OF BIRTH: <u>April 21, 1931</u>         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Md. State Rd. Com.</u>  |                                | 11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>  |   |
| 13. FATHER'S NAME: <u>Mr. James L. Wallace</u>   |                                | 14. MOTHER'S MAIDEN NAME: <u>Olive A. Baker</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)   |                                | 17. INFORMANT & ADDRESS: <u>Mr. James L. Wallace, 4815 Richard Ave #14</u>   |   |
| 18. MEDICAL CERTIFICATION  |                                |  |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:<br><u>922.8</u><br>Immediate cause (a) <u>DROWNING</u><br>DUE TO<br>Antecedent cause(s) (b)<br>Diseases or conditions, if any, giving rise to the above cause DUE TO<br>stating underlying cause last (c)   |                                |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>None</u> |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>  |                                |  |   |
| 19a. DATE OF OPERATION: <u>None</u>  |                                | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                | 21b. PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY <u>1716 Sparrows Pt - Baltimore - Md.</u>  |   |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-2-55 3:45</u> M.  |                                | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |   |
| 21f. HOW DID INJURY OCCUR? <u>Drowned while swimming from Boat.</u>  |                                |  |   |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                |  |   |
| SIGNATURE <u>M. B. Davis M.D.</u>  |                                | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/4/55</u><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAM. <input type="checkbox"/>  |   |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>  |                                | DATE THEREOF <u>July 6, 1955</u>   |   |
| NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>  |                                | LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>  |   |
| DATE REC'D BY LOCAL REG. <u>July 5, 1955</u>   |                                | 24. FUNERAL DIRECTOR <u>Leonard J. Ruck, 5305 Harford Road #14</u>   |   |
| REGISTRAR'S SIGNATURE <u>G. H. Hedrick</u>   |                                | ADDRESS <u>None</u>  |   |



CERTIFICATE OF DEATH

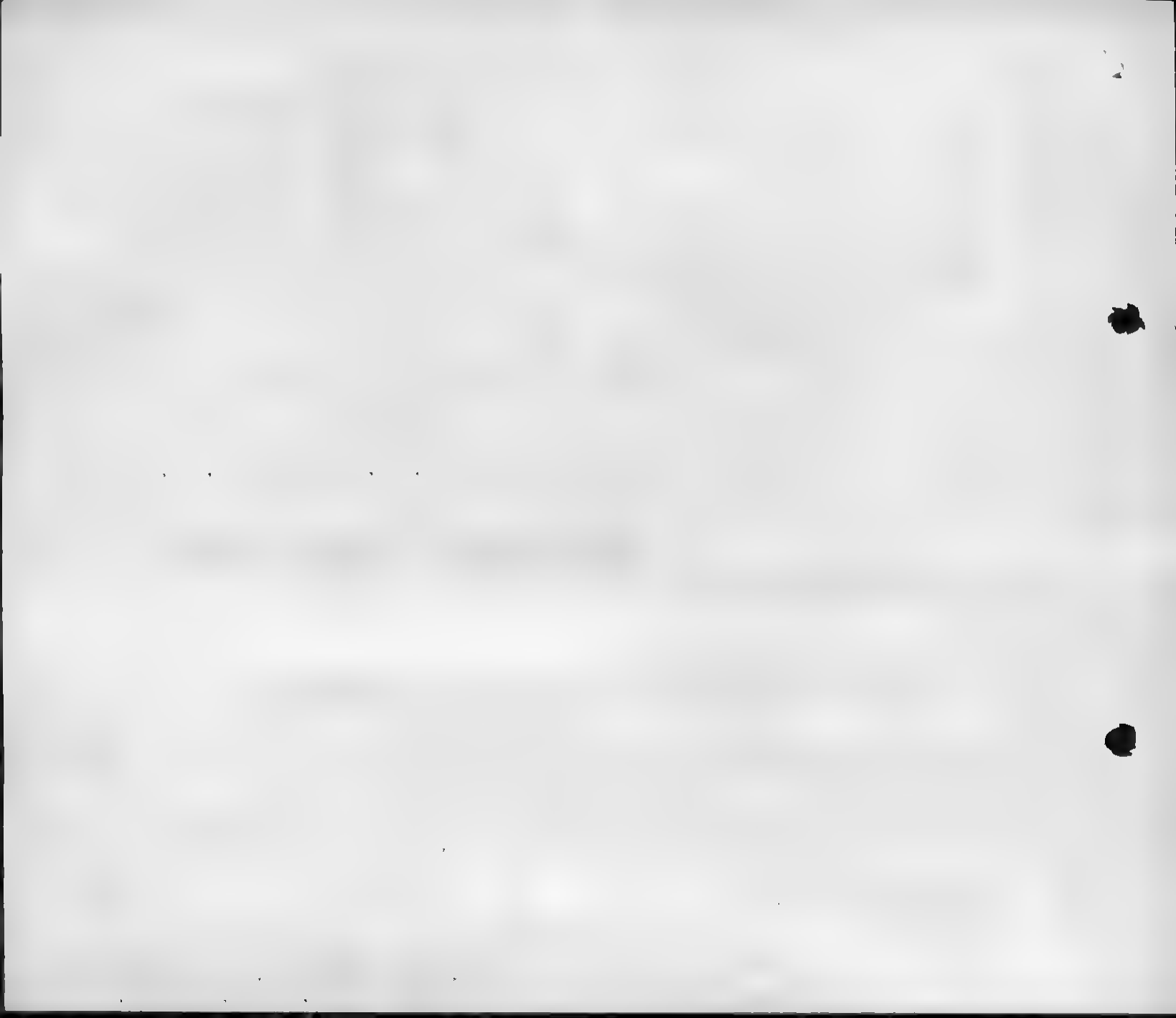
Reg. Dist. No.

6448

|   |                                |  |                                 |
|---|--------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH   |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                                 |
| COUNTY <u>Baltimore</u>   | MARYLAND                       | STATE <u>Maryland</u>  | COUNTY                          |
| CITY (If outside corporate limits, write RURAL and give nearest town)   | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town)  |                                 |
| TOWN <u>Fort Howard</u>   | <u>67 Days</u>                 | TOWN <u>Baltimore</u>  | <u>300.4</u>                    |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                                | STREET ADDRESS (If rural give location)  |                                 |
| <u>Veterans Administration Hospital</u>   |                                | <u>337 East 27th Street</u>  |                                 |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  | 4. DATE (Month) (Day) (Year)   |  |                                 |
| <u>WILLIAM G. WANTLAND</u>  | <u>July 24, 1955</u>           |  |                                 |
| 5. SEX: <u>Male</u>   | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>   | 8. DATE OF BIRTH: <u>5/4/88</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Fireman</u>   |                                | 10B. KIND OF BUSINESS OR INDUSTRY: <u>B&amp;O Railroad</u>   |                                 |
| 13. FATHER'S NAME: <u>William H. Wantland</u>   |                                | 14. MOTHER'S MAIDEN NAME: <u>Mamie Waxter</u>  |                                 |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service): <u>Yes WW I</u>   |                                | 16. SOCIAL SECURITY NO.: <u>Unknown</u>  |                                 |
| 17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>  |                                |  |                                 |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                | INTERVAL BETWEEN ONSET AND DEATH   |                                 |
| IMMEDIATE CAUSE: <u>420.1</u>   |                                |  |                                 |
| ANTECEDENT CAUSE (S):   |                                |  |                                 |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |                                |  |                                 |
| (A) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH CONGESTIVE FAILURE &amp; CORONARY INSUFFICIENCY</u>   |                                | 6 MONTHS   |                                 |
| (B) DUE TO  |                                |  |                                 |
| (C) DUE TO  |                                |  |                                 |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                                |  |                                 |
| 19A. DATE OF OPERATION  |                                | 19B. MAJOR FINDINGS OF OPERATION   |                                 |
|   |                                |  |                                 |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                | 21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.)  |                                 |
|   |                                | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |                                 |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                 |
| <u>VA M.</u>  |                                | 21F. HOW DID INJURY OCCUR?   |                                 |
| 22. I hereby certify that <u>VA</u> attended the deceased from <u>May 18, 1955</u> to <u>July 24, 1955</u> . <del>He attended the deceased from</del> <u>and that death occurred at 2:40 M. from the causes and on the date stated above.</u> |                                |  |                                 |
| SIGNATURE: <u>William E. Hill, M.D.</u>   |                                | DATE SIGNED: <u>7/24/55</u>  |                                 |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>   |                                | NAME OF CEMETERY OR CREMATORY: <u>Moreland Memorial Cemetery</u>   |                                 |
| DATE REC'D BY LOCAL REGISTRAR: <u>7-27-55</u>   |                                | LOCATION (City, town, or county) (State): <u>Baltimore, Maryland</u>   |                                 |
| REGISTRAR'S SIGNATURE: <u>Wm. Cook-Blight Inc.</u>  |                                | 24. FUNERAL DIRECTOR ADDRESS: <u>6009 Harford Rd., Balto., Md.</u>   |                                 |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply very item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

6449

06454

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH - COUNTY <u>BALTIMORE COUNTY</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Howard</u>                           |  |   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 TOWN</u>  |  |  |  | CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN Ellicott City</u> <u>12</u> |  |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HOUSE IN THE PINES 16 FURRING AVE CATONSVILLE MD</u>   |  |  |  | STREET ADDRESS (If rural, give location) <u>Angelo Cottage</u> <input checked="" type="checkbox"/>           |  |   |  |
| 3. NAME OF DECEASED (Type or Print) <u>CLARA</u> (First)  |  | <u>Bagley</u> (Middle)   |  | <u>WATKINS</u> (Last)  |  | 4. DATE OF DEATH (Month) <u>7</u> (Day) <u>11</u> (Year) <u>1955</u>  |  |
| 5. SEX <u>FEMALE</u>  |  | 6. COLOR OR RACE <u>W</u>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>  |  | 8. DATE OF BIRTH <u>6-16-76</u>                                       |  |
| 9. AGE last birthday <u>79</u> yrs.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Sunnybrook, Maryland</u> |  |
| 13. FATHER'S NAME <u>Charles Bagley Sr.</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |   |  |
| 15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY No. <u>None</u>  |  | 17. INFORMANT AND ADDRESS <u>Mrs. Clara H. Souther, Relay, Md</u>     |  |
| 18. MEDICAL CERTIFICATION   |  |  |  |  |  |   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| 470X Immediate cause (a) <u>Lobar Pneumonia</u>   |  |  |  |  |  | <u>9 da.</u>  |  |
| Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Hypertensive Cardio-Vascular Disease</u>   |  |  |  |  |  | <u>years</u>  |  |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. MAJOR FINDINGS OF OPERATION   |  |   |  |
| 21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>   |  |  |  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                             |  |   |  |
| PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>  |  |  |  | (CITY OR TOWN) (COUNTY) (STATE)  |  |   |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>  |  |  |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>            |  |   |  |
| HOW DID INJURY OCCUR?   |  |  |  |  |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>7-1</u> , 19 <u>55</u> , to <u>7-11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7-11</u> , 19 <u>55</u> , and that death occurred at <u>2</u> <u>p.</u> m., from the causes and on the date stated above. |  |  |  |  |  |   |  |
| SIGNATURE <u>William K. Gallager M.D.</u>   |  |  |  | ADDRESS <u>Catonville-28, Md.</u>  |  | DATE SIGNED <u>7-12-55</u>  |  |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>   |  |  |  | NAME OF CEMETERY OR CREMATORY <u>Fork Methodist</u>  |  |   |  |
| DATE REC'D BY LOCAL REG. <u>7-14-55</u>   |  |  |  | REGISTRAR'S SIGNATURE <u>V.E. Harry</u>  |  |   |  |
| 24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u>  |  |  |  | ADDRESS <u>Ellicott City, Md</u>   |  |   |  |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVE FOR BINDING

VS. A15

1-4 AMF

1-4 AMF

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

07534

Reg. Dist. No. ....

6450

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH:<br>COUNTY <u>Baltimore</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>Maryland</u> COUNTY <u>Baltimore</u>           |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>  |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>         |   |
| TOWN <u>Baltimore</u>  |                                  | TOWN <u>Baltimore</u>   |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>5 Farms Golf Course</u>  |                                  | STREET ADDRESS (If rural, give location)<br><u>Broadview Apts. 116 W. Union Pk.</u>               |   |
| 3. NAME OF DECEASED<br>(First) <u>Fern</u> (Middle) <u>Darlington</u> (Last) <u>Weatherway</u>   |                                  | 4. DATE OF DEATH<br>(Month) <u>July</u> (Day) <u>30</u> (Year) <u>1955</u>                        |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>                                   | 8. DATE OF BIRTH<br><u>Feb 19, 1906</u> |
| 9. AGE last birthday<br><u>49</u> yrs.   |                                  | 10. BIRTHPLACE (State or foreign country)<br><u>Michigan</u>                                      |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Michigan</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |   |
| 13. FATHER'S NAME<br><u>Fern Arthur Weatherway</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Nettie Darlington</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WWII</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>Mrs W. P. Gildea Tr.</u>  |   |
| 17. INFORMANT AND ADDRESS  |                                  |   |   |
| 18. MEDICAL CERTIFICATION  |                                  |   |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                  |   | INTERVAL BETWEEN ONSET AND DEATH        |
| Immediate cause (a) <u>Coronary Occlusion</u>  |                                  |   | <u>Sudden</u>                           |
| Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>   |                                  |   | <u>(10 min)</u>                         |
| (c)  |                                  |   |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |                                  |   |   |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |                                  |   |   |
| 21. PRIMARY OR CONTRIBUTING CAUSE OF DEATH   |                                  | PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)           |   |
| TIME (Month) (Day) (Year, (Hour) OF INJURY   |                                  | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   |
| HOW DID INJURY OCCUR?  |                                  |   |   |
| 22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from <u>accident</u> <input checked="" type="checkbox"/> <u>suicide</u> <input type="checkbox"/> <u>homicide</u> <input type="checkbox"/> <u>undetermined</u> <input type="checkbox"/> |                                  |   |   |
| SIGNATURE<br><u>Charles F. O'Donnell MD</u>  |                                  | ADDRESS<br><u>7501 York Rd - Towson 4 Md</u>  |   |
| DATE SIGNED<br><u>July 31, 1955</u>  |                                  | DATE SIGNED<br><u>Aug 11, 1955</u>  |   |
| NAME OF CEMETERY OR CREMATORY<br><u>BOYER VAN WORMER F. HOME</u>   |                                  | LOCATION (City, town, or county) (State)<br><u>Toledo Ohio</u>                                    |   |
| 23. REGISTRAR'S SIGNATURE<br><u>Anna MacRae</u>  |                                  | 24. FUNERAL DIRECTOR<br><u>John Thomas Bros Towson</u>  |   |
| DATE REC'D BY LOCAL<br><u>Aug 11, 1955</u>   |                                  | ADDRESS<br><u>Towson</u>  |   |

PLEASE WRITE PLAINLY, WITH ERASABLE INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR INDEXING



6451

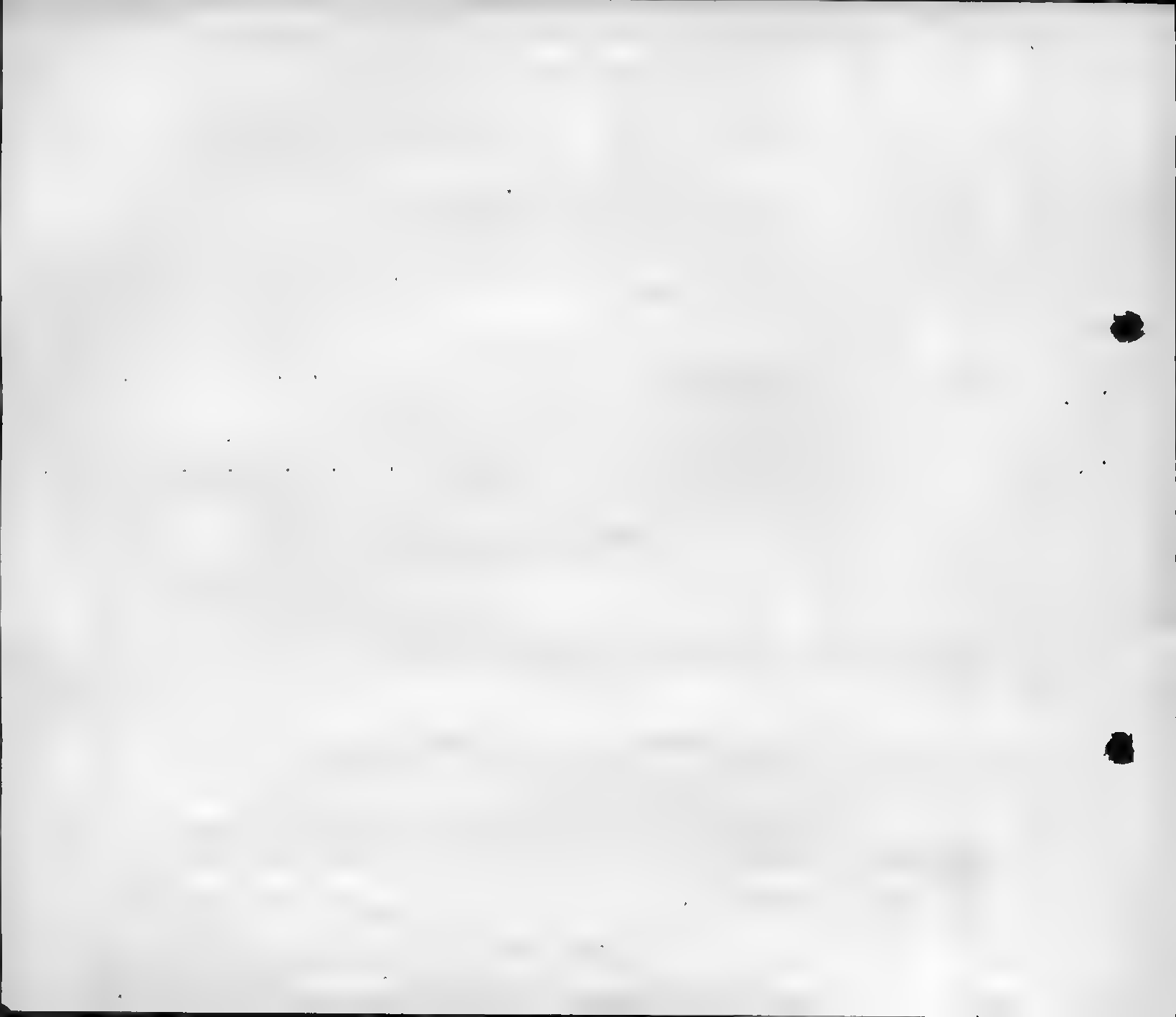
## CERTIFICATE OF DEATH

Reg. Dist. No. 64

|  |                                |  |                                  |
|--|--------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH:   |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                                  |
| COUNTY <u>Baltimore</u>  | MARYLAND                       | STATE <u>Maryland</u> COUNTY _____   |                                  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town)  |                                  |
| TOWN <u>Fort Howard</u>  | <u>1 Hour-50 M.</u>            | TOWN <u>Baltimore</u>  |                                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>  |                                | STREET ADDRESS (If rural give location) <u>3211 Batavia Avenue</u>   |                                  |
| 3. NAME OF DECEASED: (Type or Print)   |                                | 4. DATE OF DEATH   |                                  |
| (First) (Middle) (Last) <u>HENRY</u> <u>Rudolph</u> <u>WEBER</u> <u>Sr.</u>  |                                | (Month) (Day) (Year) <u>July</u> <u>24</u> <u>1955</u>   |                                  |
| 5. SEX: <u>Male</u>  | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>   | 8. DATE OF BIRTH: <u>9/30/92</u> |
| 9. AGE last birthday <u>62</u> yrs   |                                | 10. BIRTHPLACE (State or foreign country) <u>New York, N. Y.</u>   |                                  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Machine Shop</u>   |                                | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                  |
| 13. FATHER'S NAME: <u>Joseph Weber</u>   |                                | 14. MOTHER'S MAIDEN NAME: <u>Elizabeth Most</u>  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>   |                                | 16. SOCIAL SECURITY NO. <u>202-09-3401</u>   |                                  |
| 17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>   |                                |  |                                  |
| 18. MEDICAL CERTIFICATION  |                                | INTERVAL BETWEEN ONSET AND DEATH   |                                  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                                | <u>SEVERAL HOURS</u>   |                                  |
| (A) <u>HEAT STROKE</u>   |                                |  |                                  |
| IMMEDIATE CAUSE DUE TO <u>PROLONGED HOT SPELL</u>  |                                |  |                                  |
| ANTECEDENT CAUSE (B):  |                                |  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |                                |  |                                  |
| (C)  |                                |  |                                  |
| 19. DATE OF OPERATION: _____   |                                | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                | 21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc  |                                  |
| 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |                                |  |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> <u>M.</u>  |                                | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                  |
| 21F. HOW DID INJURY OCCUR? <u>10:30 P.M.</u> <u>12:20 AM.</u>  |                                |  |                                  |
| 22. I hereby certify that I attended the deceased from <u>July 23, 1955</u> , to <u>July 24, 1955</u> , and that death occurred at <u>12:20 AM</u> , from the causes and on the date stated above. |                                |  |                                  |
| SIGNATURE <u>WILLIAM B. VANDEGRIFT, M.D.</u>   |                                | ADDRESS <u>VAH, FORT HOWARD, MARYLAND 7-25-55</u>  |                                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |                                | NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>  |                                  |
| DATE THEREOF <u>July 27, 1955</u>  |                                | LOCATION (City, town, or county) <u>Baltimore, Maryland</u>  |                                  |
| DATE REC'D BY LOCAL REGISTRAR <u>7-26-55</u>   |                                | 24. FUNERAL DIRECTOR <u>Leonard J. Ruck Funeral Home</u>   |                                  |
| REGISTRAR'S SIGNATURE <u>L</u>   |                                | ADDRESS <u>5305 Harford Road, Baltimore, Md.</u>   |                                  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6452

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

|  |                              |  |  |  |   |  |  |
|--|------------------------------|--|--|--|---|--|--|
| 1. PLACE OF DEATH<br>COUNTY <u>BALTIMORE</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWN TOWSON</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>517 W. JOPPA ROAD</u>   |                              |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED.<br>STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u><br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u><br>STREET ADDRESS (If rural give location) <u>517 W. JOPPA ROAD</u> |   |  |  |
| 3. NAME OF DECEASED (First) (Middle) (Last)<br><u>MIRIAM ALLEN WEGNER</u>  |                              |  | 4. DATE (Month) (Day) (Year)<br>OF DEATH <u>JULY 5, 1955</u> |  |   |  |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>  | 8. DATE OF BIRTH.<br><u>MAY 1, 1903</u>                      |  | 9. AGE last birthday<br><u>52</u> yrs. <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>   |                              | 10B. KIND OF BUSINESS OR INDUSTRY.<br><u>OWN HOME</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |  |
| 13. FATHER'S NAME.<br><u>NEWTON D.R. ALLEN</u>   |                              |  | 14. MOTHER'S MAIDEN NAME:<br><u>ROSE E.</u>                  |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>NONE</u>   |  | 17. INFORMANT & ADDRESS.<br><u>ROLAND M. WEGNER 517 W. JOPPA RD. TOWSON 4, MD.</u>   |   |  |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                              |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>   |                              |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  |  |
| ANTECEDENT CAUSE (B) <u>Generalized arteriosclerosis</u>   |                              |  |  |  |   |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)  |                              |  |  |  |   |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Parkinsonism, severe</u>   |                              |  |  |  | <u>20 yr</u>  |  |  |
| 19A. DATE OF OPERATION:  |                              |  | 19B. MAJOR FINDINGS OF OPERATION                             |  |   |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |  | 21C. WHERE DID (City or town) (County) (State)<br>INJURY OCCUR?  |   |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><u>M</u>  |                              | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work |  | 21F. HOW DID INJURY OCCUR?   |   |  |  |
| 22. I hereby certify that I attended the deceased from <u>Jul.</u> , 19 <u>54</u> , to <u>present</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 22, 1955</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. |                              |  |  |  |   |  |  |
| SIGNATURE<br><u>Emmet C. Brown Jr.</u>   |                              | ADDRESS<br><u>M.D. 1101 22 Canal St</u>  |  | DATE SIGNED<br><u>7/8/55</u>   |   |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>  |                              | DATE THEREOF<br><u>JULY 7, 1955</u>  |  | NAME OF CEMETERY OR CREMATORY<br><u>PROSPECT HILL CEM.</u>   |   |  |  |
| LOCATION (City, town, or county) (State)<br><u>TOWSON, BALTO. CO., MD.</u>   |                              | DATE REC'D BY LOCAL REGISTRAR<br><u>July 8, 1955</u>   |  | REGISTRAR'S SIGNATURE<br><u>Mark C. King</u>   |   |  |  |
| FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Md.</u>   |                              | ADDRESS  |  |  |   |  |  |

06456





## MARYLAND STATE DEPARTMENT OF HEALTH

06457

6750

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH—<br>COUNTY <u>BALTIMORE</u> MARYLAND                               |   | 2. USUAL RESIDENCE (HOME) OF DECEASED—<br>STATE <u>MARYLAND</u> COUNTY <u>BACTO.</u> |   |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> |   | CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7233 GERMAN HILL</u>                    |   | STREET ADDRESS (If rural, give location) <u>7233 GERMAN HILL</u>                     |   |
| 3. NAME OF DECEASED (Type or Print)  | (First) <u>GEORGE</u>   | (Middle) <u>W.</u>   | (Last) <u>WHEATLEY</u>  |
| 4. DATE OF DEATH   | (Month) <u>JULY</u>   | (Day) <u>28</u>  | (Year) <u>1955</u>  |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>WHITE</u>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>                       | 8. DATE OF BIRTH <u>SEPT. 8, 1881</u>                                       |
| 9. AGE last birthday <u>73</u> yrs.  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDENER</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>FLORIST</u>                                     | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>                   |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>  | 13. FATHER'S NAME <u>JAMES W. WHEATLEY</u>  | 14. MOTHER'S MAIDEN NAME <u>MARY SCHAEFER</u>  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> |
| 16. SOCIAL SECURITY No. <u>217-24-5544</u>   | 17. INFORMANT AND ADDRESS <u>ANNA C. MERBACH 7233 GERMAN HILL</u>   |  |   |

|  |  |  |
|--|--|--|
| 18. MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |
| 1a. Immediate cause (a) <u>Arterio-sclerotic Cardiac Infection Disease</u>   |  |  |
| Antecedent cause(s) (b) <u>remedy</u>  |  |  |
| Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Ca. Throat (injury)</u> |  | <u>6 mos.</u>  |
| 2. OTHER SIGNIFICANT CONDITIONS  |  |  |
| Conditions contributing in the death but not related to the disease or condition causing death.                                |  |  |
| 19a. DATE OF OPERATION <u>Feb 1/55</u>   | 19b. MAJOR FINDINGS OF OPERATION <u>Mouth (injury) + Heart operation done</u>                                | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH  | PLACE (Home, farm, factory, street, office, etc.) <u>INJURY</u>  | (CITY OR TOWN) (COUNTY) (STATE)  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   | INJURY OCCURRED While at <input checked="" type="checkbox"/> work Not while at work <input type="checkbox"/> | HOW DID INJURY OCCUR?  |

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, or thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.

SIGNATURE William M. Kelly (Degree or title) ADDRESS 112 COLGATE RD DUNDALK DATE SIGNED 7/28/55

23. RIAL CREMATION (Specify) BORIAL DATE THEREOF AUG. 1, 1955 NAME OF CEMETERY OR CREMATORY OAK LAWN LOCATION (City, town, or county) COLGATE RD (State) MD

DATE REC'D BY LOCAL REG. July 31-1955 REGISTRAR'S SIGNATURE William M. Kelly 24. FUNERAL DIRECTOR ULLRICH FUNERAL HOME ADDRESS 112 COLGATE RD DUNDALK

MARGIN RESERVE FOR BINDING

USE WRITING PENCIL ONLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

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6453  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

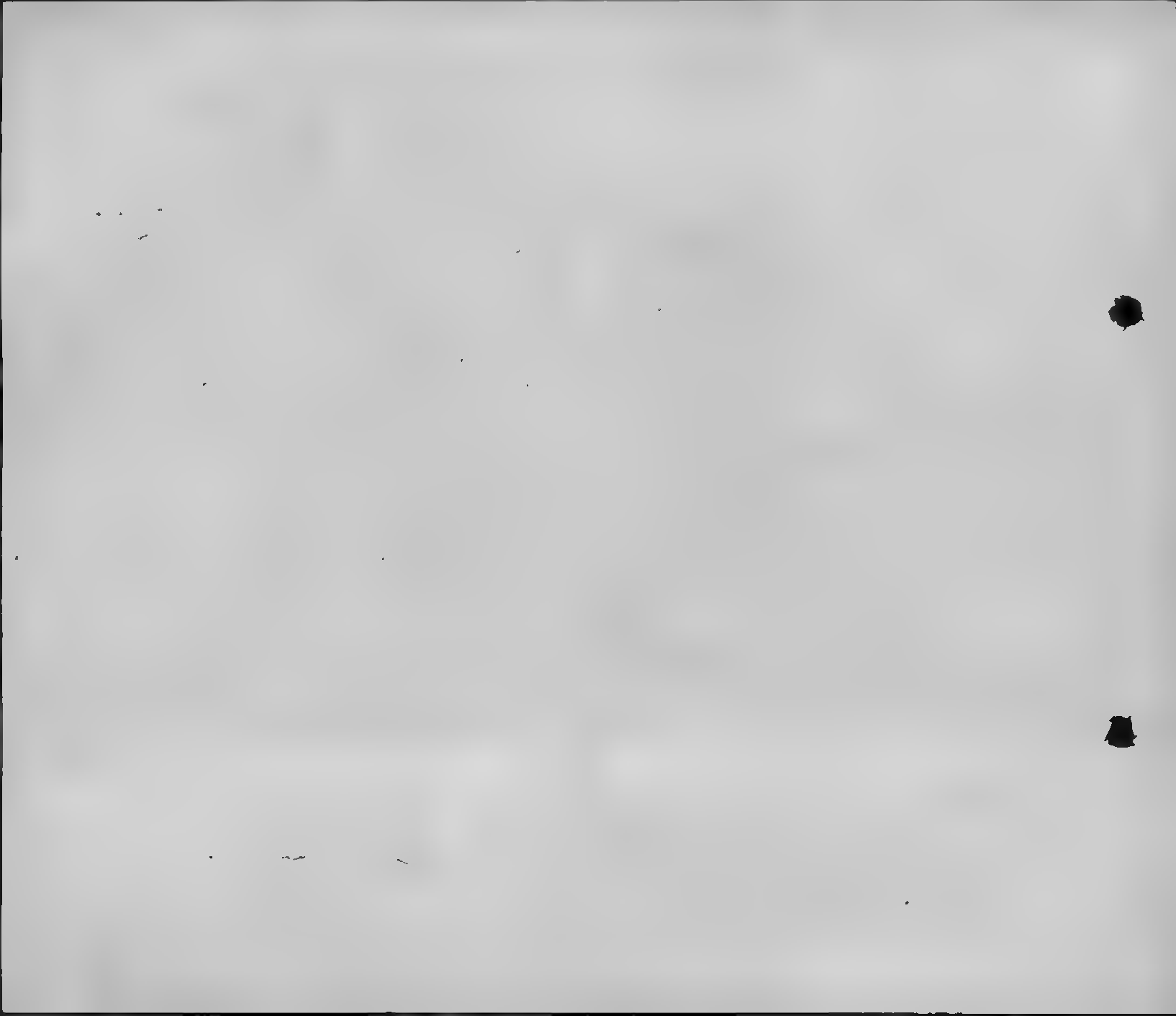
Reg. Dist.

No.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH:  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |   |
| COUNTY <i>Balto.</i>  | MARYLAND                                    | STATE <i>Pa.</i>  | COUNTY <i>Edg.</i>  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br><i>Balto 19</i>   | LENGTH OF STAY (in this place)<br><i>12</i> | CITY (If outside corporate limits write RURAL and give nearest town)<br><i>Edg.</i> | TOWN <i>Edg.</i>  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>2518 Lodge Forest Dr</i>   |   | STREET ADDRESS (If rural, give location)<br><i>Lodge Forest</i>                     |   |
| 3. NAME OF DECEASED:<br>(Type or Print) <i>Robert Gray Whippo</i>   |   | 4. DATE OF DEATH<br>Month <i>July</i> Day <i>25</i> Year <i>1955</i>                |   |
| 5. SEX: <i>Male</i>   | 6. COLOR OR RACE: <i>White</i>              | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>                    | 8. DATE OF BIRTH: <i>May 29/1895</i>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)<br><i>Apprentice &amp; Labor</i>   |   | 10b. KIND OF BUSINESS OR INDUSTRY:<br><i>Sylome Pa.</i>                             | 9. AGE last birthday: <i>60</i> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min. |
| 11. BIRTHPLACE (State or foreign country): <i>Sylome Pa.</i>  |   | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME: <i>Samuel Whippo</i>   |   | 14. MOTHER'S MAIDEN NAME:   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)  |   | 16. SOCIAL SECURITY No.: <i>2518 Lodge Forest</i>                                   |   |
| 17. INFORMANT & ADDRESS: <i>Mrs. R. Bagliano 2518 Lodge Forest</i>  |   | 18. MEDICAL CERTIFICATION   |   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  |   | INTERVAL BETWEEN ONSET AND DEATH  |   |
| 241X Immediate cause (a) DUE TO <i>Coronary occlusion</i>   |   | Antecedent cause(s) (b) DUE TO <i>Cardio Vas disease</i>                            |   |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <i>Asthma</i>  |   |   |   |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |   |   |   |
| 19a. DATE OF OPERATION:   |   | 19b. MAJOR FINDING OF OPERATION:  |   |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>   |   | (State)   |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |   | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY              |   |
| 21c. (City or town) (County)  |   | 21d. TIME (Month) (Day) (Year) (Hour) (Min) OF INJURY <i>July 25/55 5:30 P.M.</i>   |   |
| 21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 21f. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |   |   |
| SIGNATURE <i>M. D.</i>  |   | DATE SIGNED   |   |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>   |   | DATE THEREOF <i>July 27/55</i>  |   |
| NAME OF CEMETERY OR CREMATORY <i>Highland Forest</i>  |   | LOCATION (City, town, or county) (State) <i>Meyersdale Penna</i>                    |   |
| DATE REC'D BY LOCAL REG. <i>Aug 1/55</i>  |   | 24. FUNERAL DIRECTOR <i>Heckel 1701-03 Patterson Park Ave</i>                       |   |

MARGIN RESERVED FOR BINTING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6451

## CERTIFICATE OF DEATH

Reg. Dist. No. 30.....

## 1. PLACE OF DEATH:

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR TOWNHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR TOWNSTREET  
ADDRESS

(If rural give location)

3. NAME OF  
DECEASED:  
(Type or Print)

5. SEX:

6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDDED, DIVORCED,  
(Specify)

8. DATE OF BIRTH:

4. DATE (Month) (Day) (Year)  
OF  
DEATH:9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.  
yrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during last working life, even if retired)

10B. KIND OF BUSINESS  
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country).

12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS:

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.(A)  
DUE TO(B)  
DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.INTERVAL BETWEEN  
ONSET AND DEATH

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory  
OF INJURY street office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR? (County) (State)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While ☐ Not while ☐  
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/9/54 to 7/19/55, that I last saw the deceased alive on 7/19/55, 19, and that death occurred at 5:15 P.M. from the cause and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REGISTRAR

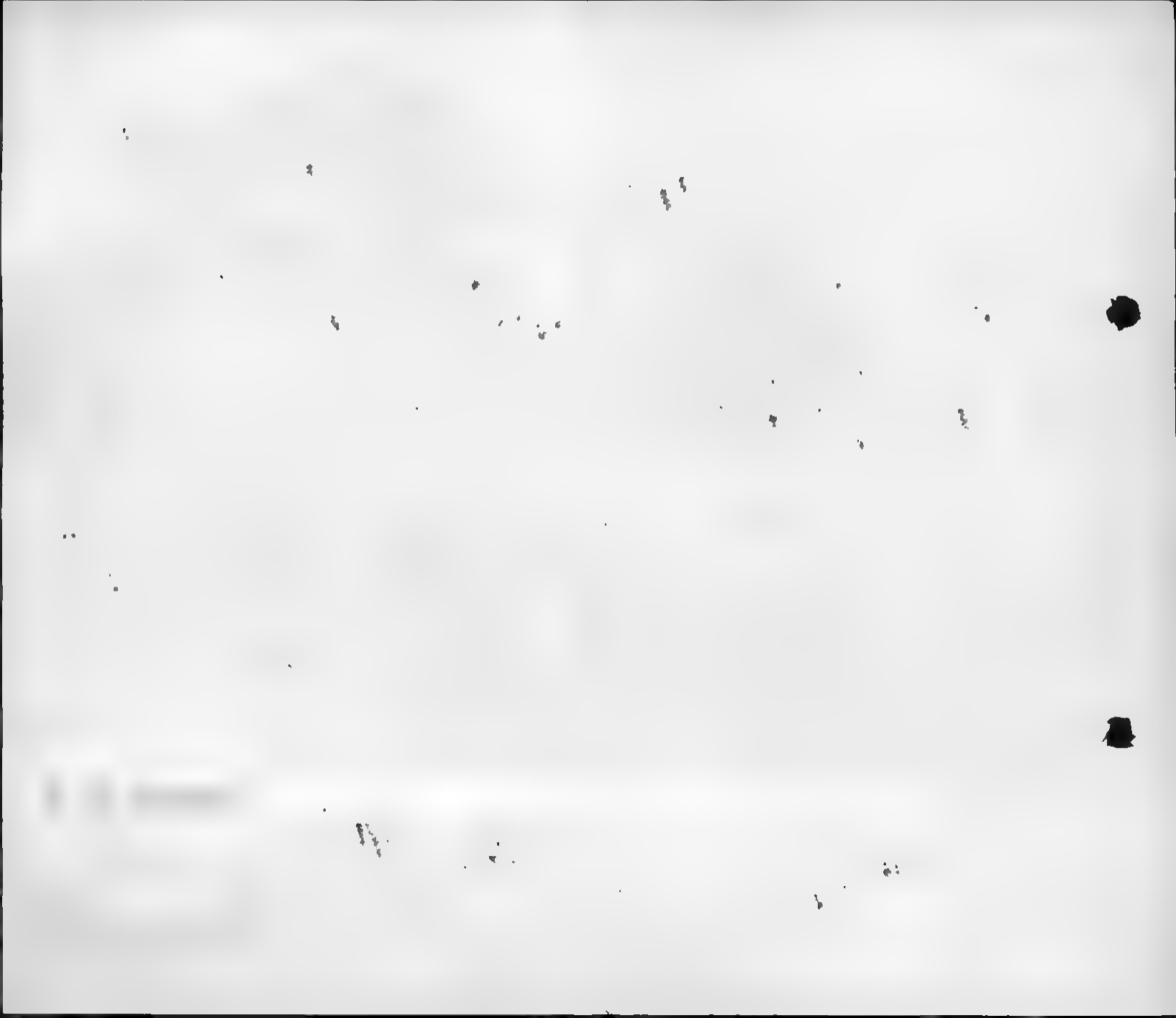
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6455

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH:   |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                |  |  |  |
| COUNTY <u>BALTO.</u> MARYLAND  |  | CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>   |  | STATE <u>MD.</u> COUNTY <u>BALTO.</u>                                 |  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u> |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 RIDGEWAY MANOR</u>   |  | LENGTH OF STAY (In this place) <u>2 YRS.</u>   |  | STREET ADDRESS (If rural give location) <u>5743 EDMONDSON AVE</u>     |  |  |  |
| 3. NAME OF DECEASED: (First) <u>BETTY</u> (Middle) <u>M</u> (Last) <u>WILEY</u>  |  |  |  | 4. DATE (Month) (Day) (Year) OF DEATH: <u>7</u> <u>18</u> <u>1955</u> |  |  |  |
| 5. SEX: <u>F</u>   |  | 6. COLOR OR RACE: <u>W</u>   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOW</u>        |  | 8. DATE OF BIRTH: <u>5-5-1867</u>  |  |
| 9. AGE last birthday: <u>88</u> yrs.   |  | 10. IF UNDER 1 YEAR: <u>2</u> Months   |  | 11. IF UNDER 24 HRS.: <u>13</u> Days                                  |  | 12. IF UNDER 24 HRS.: <u>13</u> Hours  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Housekeeping</u>                |  | 11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>                             |  |
| 13. FATHER'S NAME: <u>CHRISTOPHER C. SLADE</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME: <u>MISS CARLON</u>                          |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO. <u></u>                                       |  | 17. INFORMANT & ADDRESS: <u>EMMA WILEY WHITE HALL, MD.</u>                             |  |
| 18. MEDICAL CERTIFICATION  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (A) <u>443X Cerebro Vascular Accident</u>  |  |  |  |   |  |  |  |
| ANTECEDENT CAUSE (B) <u>Hypertensive Cardio Vascular Disease</u>   |  |  |  |   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>  |  |  |  |   |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>  |  |  |  |   |  |  |  |
| 19A. DATE OF OPERATION: <u></u>  |  |  |  | 19B. MAJOR FINDINGS OF OPERATION <u></u>                              |  |  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?          |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR? <u></u>                                    |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>SEPT.</u> , 1953 to <u>July</u> , 1955, that I last saw the deceased alive on <u>7-12</u> , 1955 and that death occurred at <u>11:30AM</u> , from the causes and on the date stated above. |  |  |  |   |  |  |  |
| SIGNATURE <u>P. V. Houch</u>   |  | ADDRESS <u>M.D. RANDALLSTOWN</u>   |  | DATE SIGNED <u>7-8-55 MD.</u>   |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | DATE THEREOF <u>7/20/55</u>  |  | NAME OF CEMETERY OR CREMATORY <u>Bethel</u>                           |  | LOCATION (City, town, or county) (State) <u>Madonna Md</u>                             |  |
| DATE REC'D BY LOCAL REGISTRAR <u>7/18/55</u>   |  | REGISTRAR'S SIGNATURE <u>V.E. Harry</u>  |  | 24. FUNERAL DIRECTOR <u>Charles C. Kutz</u>                           |  | ADDRESS <u>Garrettsville Md</u>  |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## 06462

## Reg. Dist. No. ....

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information ~~carefully~~. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE A. OVERMAN

SALE

06463

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6456

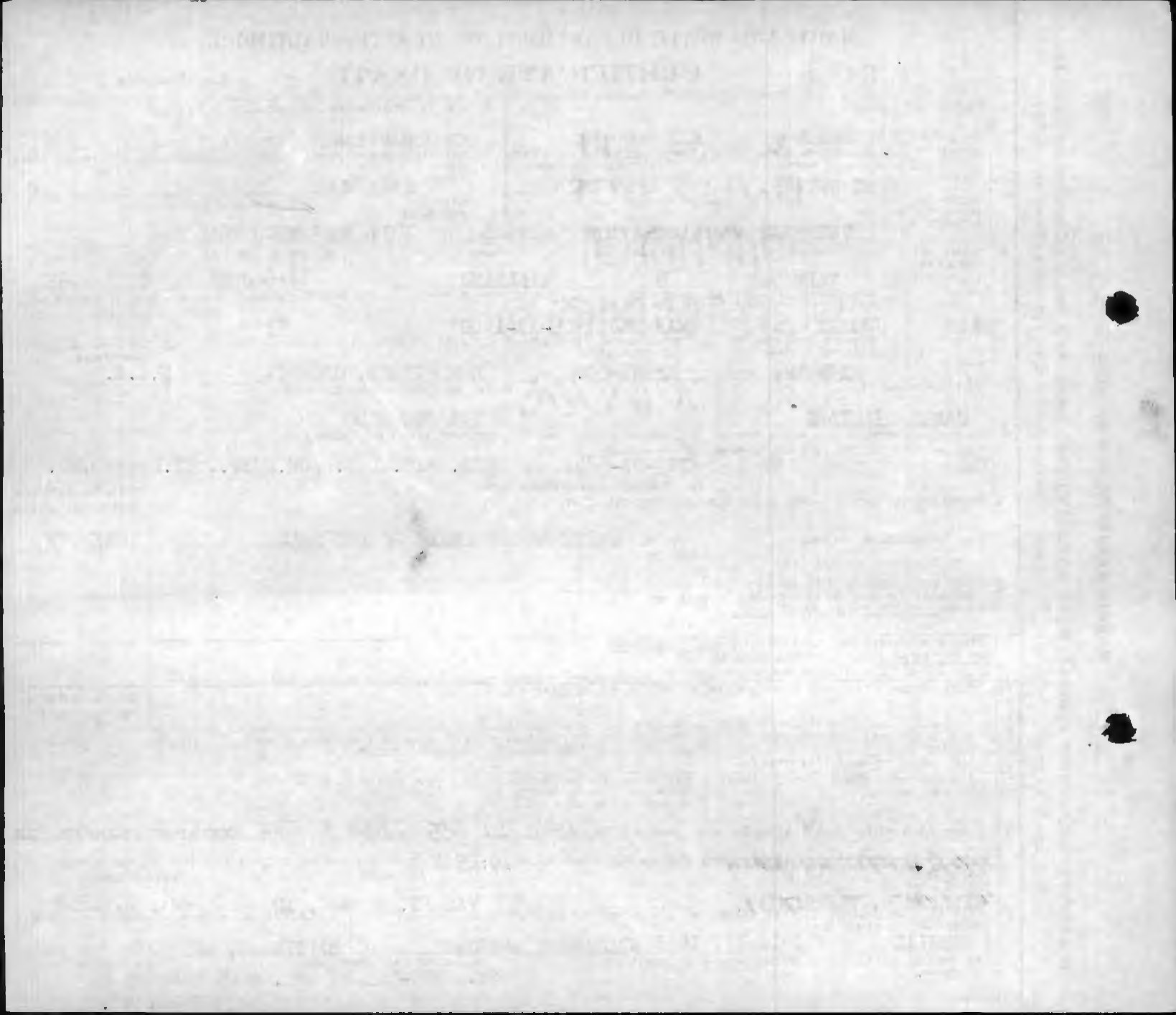
## CERTIFICATE OF DEATH

Reg. Dist. No. 44

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH:  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |   |
| COUNTY <b>BALTIMORE</b>   | MARYLAND                                      | STATE <b>MARYLAND</b>  | COUNTY <b>Baltimore</b>                               |
| CITY (If outside corporate limits, write RURAL OR TOWN) <b>FORT HOWARD,</b>   | LENGTH OF STAY (in this place) <b>89 DAYS</b> | CITY (If outside corporate limits, write RURAL OR TOWN) <b>BALTIMORE</b>   | (22) <b>X</b>   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>50 VETERANS ADMINISTRATION HOSPITAL</b>  |   | STREET ADDRESS <b>1917 ROBINWOOD ROAD</b>  |   |
| 3. NAME OF DECEASED:  |   | 4. DATE OF DEATH:  |   |
| (First) <b>TALMADGE</b>   | (Middle) <b>D</b>                             | (Last) <b>WILLIAMS</b>   | (Month) <b>JULY</b> (Day) <b>8</b> (Year) <b>1955</b> |
| 5. SEX: <b>MALE</b>   | 6. COLOR OR RACE: <b>WHITE</b>                | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>MARRIED</b>   | 8. DATE OF BIRTH: <b>5-17-1900</b>                    |
| 9. AGE last birthday: <b>55 yrs.</b>  |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>PAINTER</b>   |   |
| 11. BIRTHPLACE (State or foreign country): <b>HOMERVILLE, GEORGIA</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |
| 13. FATHER'S NAME: <b>JAMES WILLIAMS</b>  |   | 14. MOTHER'S MAIDEN NAME: <b>IDA JOURNING</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>YES</b>   |   | 16. SOCIAL SECURITY NO. <b>217-07-6842</b>   |   |
| 17. INFORMANT & ADDRESS: <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>  |   |  |   |
| 18. MEDICAL CERTIFICATION   |   |  | INTERVAL BETWEEN ONSET AND DEATH                      |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |   |  |   |
| IMMEDIATE CAUSE (A) <b>CARCINOMA OF HEAD OF PANCREAS</b>  |   |  | UNKNOWN   |
| ANTECEDENT CAUSE (B) DUE TO   |   |  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO  |   |  |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |   |  |   |
| 19A. DATE OF OPERATION: <b>2</b>  |   | 19B. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |   |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?  |   |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>VA</b>   |   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 21F. HOW DID INJURY OCCUR?  |   |  |   |
| 22. I hereby certify that <b>X</b> attended the deceased from <b>APRIL 10, 1955</b> , to <b>JULY 8, 1955</b> , and that death occurred at <b>10:45 AM</b> from the causes and on the date stated above. |   |  |   |
| SIGNATURE <b>WILLIAM B. VANDEKRIET</b>  |   | DATE SIGNED <b>July 8, 1955</b>  |   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |   | NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>  |   |
| DATE REC'D BY LOCAL REGISTRAR <b>7-11-55</b>  |   | 24. FUNERAL DIRECTOR ADDRESS <b>WM. COOK-BLIGHT INC. 6009 HARFORD RD BALTIMORE, MD.</b>  |   |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6457

CERTIFICATE OF DEATH

Reg. Dist. No. 15

06465  
44

|   |                   |   |                   |   |                     |   |                      |
|---|-------------------|---|-------------------|---|---------------------|---|----------------------|
| 1. PLACE OF DEATH:  |                   |   |                   | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |                     |   |                      |
| COUNTY <b>BALTIMORE</b>   |                   | MARYLAND  |                   | STATE <b>MARYLAND</b>   |                     | COUNTY <b>H.A.</b>  |                      |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  |                   | LENGTH OF STAY (in this place)                    |                   | CITY (If outside corporate limits, write RURAL and give nearest town) OR              |                     |   |                      |
| X TOWN <b>FORT HOWARD</b>   |                   | <b>10 DAYS</b>                                    |                   | TOWN <b>GLEN BURNIE</b>   |                     | <b>02X-2</b>  |                      |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>   |                   |   |                   | STREET ADDRESS (If rural give location) <b>25 FIFTH AVENUE S.W.</b>                   |                     |   |                      |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |                   |   |                   | 4. DATE (Month) (Day) (Year)  |                     |   |                      |
| <b>ANTON (NMI) ZEMAN</b>  |                   |   |                   | <b>JULY 16 19 55</b>  |                     |   |                      |
| 5. SEX:   | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday:   | 10. IF UNDER 1 YEAR | 11. IF UNDER 24 HRS.  | 12. IF UNDER 24 HRS. |
| <b>MALE</b>   | <b>WHITE</b>      | <b>MARRIED</b>                                    | <b>6/4/79</b>     | <b>76 yrs.</b>  | <b>Months</b>       | <b>Days</b>   | <b>Hours</b>         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>TAILOR</b>  |                   |   |                   | 10B. KIND OF BUSINESS OR INDUSTRY:  |                     | 11. BIRTHPLACE (State or foreign country): <b>AUSTRIA, HUNGARY</b>          |                      |
| 13. FATHER'S NAME: <b>JOSEPH ZEMAN</b>  |                   |   |                   | 14. MOTHER'S MAIDEN NAME: <b>MARY MN; UNKNOWN</b>                                     |                     | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                  |                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If Yes, give war or dates of service: <b>YES</b>  |                   |   |                   | 16. SOCIAL SECURITY NO. <b>213-14-4463</b>  |                     | 17. INFORMANT & ADDRESS: <b>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</b> |                      |
| 18. MEDICAL CERTIFICATION   |                   |   |                   |   |                     |   |                      |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                   |   |                   |   |                     |   |                      |
| <b>443X</b>   |                   |   |                   |   |                     |   |                      |
| IMMEDIATE CAUSE (A) <b>CEREBROVASCULAR ACCIDENT</b>   |                   |   |                   |   |                     |   |                      |
| ANTECEDENT CAUSE (B) <b>DUE TO ARTERIOSCLEROTIC &amp; HYPERTENSIVE CARDIO-VASCULAR DISEASE</b>  |                   |   |                   |   |                     |   |                      |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)   |                   |   |                   |   |                     |   |                      |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                   |   |                   |   |                     |   |                      |
| 19A. DATE OF OPERATION: <b>0</b>  |                   |   |                   | 19B. MAJOR FINDINGS OF OPERATION  |                     |   |                      |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                   |   |                   |   |                     |   |                      |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                   |   |                   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                |                     |   |                      |
| 21C. WHERE DID (City or town) (County) (State)  |                   |   |                   | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                       |                     |   |                      |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                   |   |                   | 21F. HOW DID INJURY OCCUR?  |                     |   |                      |
| 22. I hereby certify that I attended the deceased from <b>JULY 6</b> , 19 <b>55</b> , to <b>JULY 16</b> , 19 <b>55</b> , that I last saw the deceased on <b>JULY 16, 1955</b> and that death occurred at <b>5:40 P.M.</b> from the causes and on the date stated above. |                   |   |                   |   |                     |   |                      |
| SIGNATURE <b>WALTER S. PIJANOWSKI, M.D.</b>   |                   |   |                   | ADDRESS <b>VAH, FORT HOWARD, MD.</b>  |                     |   |                      |
| DATE SIGNED <b>7/17/55</b>  |                   |   |                   |   |                     |   |                      |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |                   |   |                   | NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN CEMETERY</b>                              |                     |   |                      |
| DATE <b>JULY 18, 1955</b>   |                   |   |                   | LOCATION (City, town, or county) <b>GLEN BURNIE, MARYLAND</b>                         |                     |   |                      |
| DATE REC'D BY LOCAL REGISTRAR <b>July 18, 1955</b>  |                   |   |                   | REGISTRAR'S SIGNATURE <b>Dr. Dawson L. Varbes</b>                                     |                     |   |                      |
|   |                   |   |                   | ADDRESS <b>HOPPING &amp; KIRKLEY FUNERAL HOME 421 CRAIN HIGHWAY, GLEN BURNIE, MD.</b> |                     |   |                      |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 22 1955

RECEIVED